UNITED STATES DISTRICT COURT

IN THE DISTRICT OF IDAHO

SAINT ALPHONSUS MEDICAL CENTER - NAMPA, INC., TREASURE VALLEY HOSPITAL LIMITED PARTNERSHIP, SAINT ALPHONSUS HEALTH SYSTEM, INC., AND SAINT ALPHONSUS REGIONAL MEDICAL CENTER, INC., Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD., and ST. LUKE'S REGIONAL MEDICAL CENTER, LTD., Defendants.	Case No. 1:12-cv-00560-BLW	
	Bench Trial	
	Witnesses:	
	David Dranove	
	Christopher Roth (Video)	
	Jeff Taylor (Video)	
	Peter A. LaFleur (Video)	
	Gary L. Fletcher (Video)	
	James Souza (Video)	
	Erik Heggland (Video)	
	Jonathan Schott (Video)	
FEDERAL TRADE COMMISSION; STATE OF IDAHO, Plaintiffs, vs. ST. LUKE'S HEALTH SYSTEM, LTD.; SALTZER MEDICAL GROUP, P.A., Defendants.	Case No. 1:13-cv-00116-BLW	

*** * * SEALED * * ***

REPORTER'S TRANSCRIPT OF PROCEEDINGS

before B. Lynn Winmill, Chief District Judge

Held on October 2, 2013

Volume 8, Pages 1281 to 1466

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PROCEEDINGS

October 2, 2013

***** COURTROOM OPEN TO THE PUBLIC *****

THE CLERK: The court will now hear Civil Case 12-560-S-BLW, Saint Alphonsus Medical Center, Nampa, Inc., versus St. Luke's Health System, for Day 8 of a bench trial.

THE COURT: Good morning, Counsel.

I think that there were two or three depositions that were read yesterday, and I need to formally publish those.

Ms. Gearhart, would you publish the three depositions that we were reading yesterday.

THE CLERK: The deposition of Kathy Moore, Gregory Dean Orr and Christopher Roth are published.

(Depositions of Kathy Moore, Gregory Dean Orr, and Christopher Roth published.)

THE COURT: Thank you.

Counsel, I forget where we were. I can't get my notes up yet. Perhaps you could -- Ms. Duke.

MS. DUKE: Sure, Your Honor. One preliminary matter: Exhibit 1000 was admitted on September 26th, 2013, page 539 of the transcript, lines 17 through 19, and it wasn't noted in the official record in the very beginning indicating its admission, so I just wanted that to be clear that 1000 is, in fact, admitted.

THE COURT: My notes indicate that it was admitted

on September 26th. Is that the date?

MS. DUKE: Correct, yes.

THE COURT: Yes, that's what my notes indicate.

MS. DUKE: Perfect. So I don't know how -- if we just revise the transcript to indicate on that date that it just needs to be added.

THE COURT: All right. Then perhaps I -- well, to the -- I think we can -- I think what we're saying here is on the record --

MS. DUKE: Okay.

THE COURT: -- and we can indicate that the exhibit was admitted on that date. And if it didn't make its way onto the transcript, it -- presumably it's because I wasn't clear enough. But I am being clear now, hopefully.

MS. DUKE: Perfect. Thank you, Your Honor.

MR. HERRICK: Your Honor, plaintiffs call Dr. David Dranove to the stand.

THE COURT: I assume he is here in the courtroom.

MR. HERRICK: We're going to go get him.

THE COURT: All right. If you would.

Dr. Dranove, would you please step before Ms. Gearhart to be sworn as a witness and then follow her directions from there.

DAVID DRANOVE,

having been first duly sworn to tell the whole truth,

testified as follows:

THE CLERK: Please take a seat in the witness stand.

MR. HERRICK: Your Honor, we have a few binders that we would like to hand up, if we could hand them to Mr. Metcalf, please.

THE COURT: Yes.

THE CLERK: Please state your complete name and spell your name for the record.

THE WITNESS: David Dranove, D-R-A-N-O-V-E, first name is the usual spelling.

THE COURT: You may inquire of the witness.

MR. HERRICK: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. HERRICK:

Q. Before we get started, Professor Dranove, I understand you have been under the weather. Can you just tell us how you're feeling today?

A. I'm doing okay. Maybe a little bit subdued. That might be good though. It might make me a little clearer. Thank you.

Q. Professor Dranove, in front of you are -- is a binder containing a few documents. Can you please open the binder and take a look at the documents labeled as your reports, please.

A. Mm-hmm.

Q. Can you describe those records for the record, please.

MR. STEIN: I'm sorry. Could I get a copy of the binder?

THE WITNESS: Sure. After the first tab are slides that I prepared that I will walk through during my testimony today. It's followed by my initial expert report, my curriculum vitae, and then my reply report.

BY MR. HERRICK:

Q. Thank you. And just so the record is clear, the expert reports have been marked Plaintiffs' Exhibit 1848 and 1849.

Focusing on the reports that are before you, Professor Dranove, do you stand by and adopt the statements set forth in those reports?

A. Yes, I do.

Q. Okay. Let's turn to your qualifications. If I could ask you to turn to the tab that's marked for your CV. Do you see that?

A. Yes.

Q. Just at a very high level, could you briefly describe your experience in the field of healthcare economics?

A. Sure. I've been studying healthcare economics for

1290

over 30 years. A large body of my work studies market forces in healthcare in general with a particular focus on competition among hospitals.

Q. And does the CV that is in the binder reflect -- or accurately reflect your work in this field?

A. Yes, it does.

Q. And what is your current title?

A. I am the Walter McNerney distinguished professor of health industry management and the director of the Health Enterprise Management Program at the Kellogg School of Management at Northwestern University.

Q. Now, as set forth in your CV, you have quite an extensive list of publications. If you could just maybe highlight a few for the court just to give a sense of your background in that regard.

A. Sure. There is a series of papers in the 1990s pertaining to the changing nature of competition in healthcare. One in particular on page B6, "The Price and Concentration in Hospital Markets: The Switch from Patient-Driven to Payer-Driven Competition," lays out, I think, the foundations of selective contracting, which is something I'll be talking about today. Taking together a large body of these papers, I ended up summarizing in two different trade books that I published for the Princeton University Press, including the Economic Evolution of

1291

American Healthcare.

Q. In connection with your published works, have you received any awards?

A. I have received several paper of the year prizes from various organizations, mainly pertaining to my research on healthcare competition.

Q. Let me back up for a little bit just for a second. What sparked your interest in healthcare economics?

A. I was an MBA student at Cornell University, and I took a course in health economics because healthcare was, at the time, a big growing part of the economy, and even back then people were worried about rising healthcare spending. And I really enjoyed the course, the professor asked me to be a research assistant for him, and the rest is history.

Q. Mr. Oxford, if we could bring of Professor Dranove's slides, please.

Professor Dranove, we've talked a little bit about your background. Were you asked to perform an analysis of healthcare markets in this case?

A. Yes, I was.

Q. And I'm going to skip ahead a little bit to get to where we discuss that in the slides.

Can you please describe the scope of your assignment in this case?

A. I was asked to assess the potential impact of the

1292

St. Luke's acquisition of Saltzer on competition in the relevant market that I assessed.

Q. Were you compensated for your time in this case?

A. Yes, I was.

Q. And in connection with that, did you make any promises to the FTC or the State of Idaho about your conclusions or the outcome of the case?

A. No. I was reimbursed for my time, not paid for my opinions.

Q. Have you ever turned down work when you couldn't support the position your potential client wanted to take?

A. Yes, I have.

Q. Any examples you can think of?

A. There was a case in Reno, Nevada, and I don't remember the details, but I remember that the parties involved, who would have been plaintiffs in an antitrust case, I don't believe they were going to be able to show that the defendants had market power, and I told them that, and I eventually -- well, I didn't get the case. I told them I wasn't going to give them the answers that they wanted, at least I didn't think the facts were going to lead to that conclusion, and I didn't get the case.

Q. Were those potential clients, were they merging entities?

A. No.

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Q. What was their --

A. They were -- I don't remember the details, but I believe it was a physician group that was claiming that a hospital in the market had market power, and that that market power was working to the disadvantage of the physician group.

Q. Have you ever performed any services for parties that were considering a merger?

A. I have done some work for -- I don't think I can name the parties, but they were -- they were healthcare organizations, not necessarily provider organizations. And on more than one occasion I have done analyses on their behalf of whether or not the FTC would be likely to approve a merger, and in one case we recommended to them that they go ahead and attempt to gain approval. In another case I recommended that they do not try to gain approval. I did not think that the FTC would look kindly on that merger.

Q. Okay. Thank you. Let's turn to some specifics here. Let's talk about the kinds of evidence you considered to reach your expert opinion in this case.

A. Sure. I am a big believer in trying to gather multiple types of evidence. There is always the data, the empirical evidence the economists love to focus on in their office in front of their computer; but I think it's equally important to get the facts on the ground for market

1294

participants, so I looked at a lot of testimonial evidence and documentary evidence, as well.

Q. Shifting gears again, let's talk a little bit about St. Luke's Saltzer and the Treasure Valley.

A. Sure.

Q. First, I'm going to put up on the big screen a map. If you could just sort of briefly describe what we're seeing here.

A. Sure. This is just a map of the major cities in the Treasure Valley. It highlights Nampa, which of course is the focus of my testimony, but also shows that it's surrounded by two other fairly large cities, Caldwell and Meridian, and then at the far east end of the Treasure Valley is the capital, Boise.

Q. Let's turn to -- excuse me. One of the merging parties here is St. Luke's. What are some of the relevant facts about St. Luke's that you considered, at least at the initial stage of your analysis?

A. When I looked at the facts about St. Luke's, it looked to me typical of a large system that has become or is attempting to become a dominant system in its market. Around the country we see this in many locations. In Boston there has been concerns about Partners, in the Bay Area there has been concerns about Sutter.

St. Luke's is the largest provider of hospital

1295

services in the Treasure Valley. It has some unique services that are not offered by other hospitals. It employs more physicians than other hospitals. And, in fact, it wasn't just my own gut reaction that this was a dominant system. I noted that a Saltzer physician, Dr. Page, even described it as the dominant system in the Treasure Valley. And that term "dominant" is one that you hear people throw around now when they look at systems in various cities around the country.

Q. It's interesting you mentioned the word "dominant." Was that conclusive in your mind at that point in your analysis?

A. No. I have never actually done a full-blown analysis of St. Luke's position. It has the characteristics of a dominant system.

Q. Up on the slide, there is -- there is a bullet on the Mercy Physician Group. Can you tell me a little bit about that and where that fits into your analysis?

A. Sure. The Mercy Physician Group was a large group of primary care providers in Nampa, and Saltzer, as part of its growth strategy -- I'm sorry -- St. Luke's, as part of its growth strategy, has been acquiring primary care physicians throughout the Treasure Valley. And this was one of their most recent acquisitions and immediately gave them a major presence in Nampa.

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Q. Okay. Well, we've talked a little bit about St. Luke's. Let's talk about Saltzer. What facts did you initially consider in your analysis regarding Saltzer?

A. Well, the important thing to me was to note that Saltzer was the largest physician group in Nampa, not just in primary care, but overall as a multispecialty group practice. But they are also certainly the largest provider of primary care in Nampa. And interestingly, they, too, have been characterized as a dominant provider in their sphere.

Q. Again, the word "dominant" has appeared. But did you consider that description to be conclusive for your analysis?

A. Again, I like to look at lots of different evidence. I take seriously what other people say, the people who are aware of the day-to-day situation in the market, but I am going to look at data. I'm an economist. It's natural for me to dig beyond what people say and see what the data says.

Q. Okay. We've talked a little bit about the who and the where. Let's turn to the hows. Specifically, I'm going to ask you to talk about the analytic framework you used to assess the proposed acquisition that's before the court.

So can you just, at a high level, explain the analytic framework you used in this case.

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A. Sure. I think I might abstract away from this slide and talk more generally, since we're really talking about a lifetime's worth of research. In order to understand what's called "selective contracting," which is really getting to the heart of this case, I think it's very useful to try to get a handle on what happened in the world of healthcare before selective contracting.

Going back 25, 30 years or so, and before that, health insurers paid a passive role in competition. By and large, if you had health insurance you can see any licensed provider in your state, and your health insurer would basically pay the bills. You would be responsible, as a patient, for a nominal cost share, say 10 percent or 20 percent of the bill.

There was a lot of research that discussed whether you could have a competitive market when you had what I described in that 1993 paper that I mentioned earlier, patient-driven competition. Patients paid a small percentage of the bill, which meant that they weren't as sensitive to price differences between providers. And on top of that, back then and to this day, prices are not transparent. There has been a lot written about pricing transparency recently, and it was true back 25 years ago, as well. It's difficult for patients to shop around. Most of the time when you have a problem you don't even know what's

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wrong with you.

So from my most recent medical condition, for example, I knew I needed to see the doctor, but I had no idea what type of visit that was going to be, what diagnostic tests might be performed, what drugs he might prescribe. And for me to comparison shop with what the cost of my medical care would be for that doctor versus the cost of medical care for some other doctor would be essentially impossible. So I wouldn't know what questions to ask.

So you have a situation where patients are insulated against price differences because of insurance and have a hard time seeing what the prices are. And naturally price is not going to be a major strategic factor. I remember talking about this with my colleague, Dennis Carlton, who has gone on to become a very prominent antitrust economist. And he asked me at the time, "Then why aren't the prices infinity?"

And I told him, "Well, they're not there yet, but they're getting there pretty quickly." In fact, prices were going up 10 percent a year or faster.

Well, into the fray jumped health insurers, in large part by some changes in state regulations. Insurers began negotiating directly with providers in what's known as "selective contracting." Insurers would assemble what we know today as "networks." And a network of providers is the

1299

set of providers who have agreed to give the insurer discounted prices, and in exchange the insurer has agreed to get into all these low cost-sharing rates if they visit those preferred providers, the providers in the network.

This led immediately to dramatic reductions in prices, 10 percent, 20 percent, sometimes 30, even 40 percent reductions in prices.

So when we talk about how you can get low prices in healthcare, to this day, we're talking about what goes on between insurers and providers. Relying on patients choosing their physicians to discipline provider pricing didn't work, and the institutional settings really haven't changed in 25, 30 years to suggest that it would work any better today.

Q. You mentioned your recent visit to a physician. Was that a PCP?

A. That was a primary care physician. I would like to say I was trying to get -- do some field research, but, in fact, I was really rather -- rather not well. But I'm -- fortunately, he seems to have prescribed the right medicine, and I am managing just fine.

Q. So just to, I guess, get a little bit more specific about this negotiating dynamic you just described that came about about 25 years ago or thereabouts, typically, where is the focal point of those negotiations,

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in your experience?

A. At any negotiation, each party asks itself, what will happen if I walk away from this deal. Suppose the other party is asking too much of me; I'm going to have to walk away from the deal. It's the only way I can avoid giving them more than I want to give them. Well, what will happen to me is based on my best outside option.

I was reading Jeffrey Crouch's testimony transcript, and he says -- he referred to it as the "BATNA," the best alternative to a negotiated agreement. That is just an industry term for what economists will talk about as your best outside option.

If you think about it this way, if you were going to go in to buy -- say you wanted to buy a Toyota, and you really liked that Toyota. You desperately want to get that Toyota. And you go to the dealer, and you tell the dealer, "You know what, I love that car. I'm not walking out of this dealership until I have that car." You're never going to get a good deal from that deal. That's the worst negotiating tactic. The best thing you could do is go in to the dealer and tell the dealer how much you love Hondas, what a great deal you're getting on the Honda. Show them the offer from the Honda dealer. The party who is best able to walk away from the deal is the one who usually comes out best from the bargain.

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And so if an insurer is negotiating with a provider, if the insurer feels that it's got a good alternative, it can drop that provider from the network and still have a viable network that it could sell to its customers, it's going to do better in the bargain than an insurer that does not have this option.

In terms of what that means, where that's going to manifest itself, if you actually look at these contracts between insurers and providers, they're long, they're messy, they're negotiating over dozens and sometimes hundreds of different prices. And you could lay these out in a spreadsheet and study all the different prices and all the different categories until your eyes go bleary.

But the thing to focus on -- and folks who do these negotiations will tell you -- the thing to focus on, if you could picture this spreadsheet, is this cell in the bottom right, which is the total amount you expect as an insurer to pay to the providers. And if providers have more bargaining leverage because the insurers can't walk away from them, you can expect the providers to get more in the bottom right-hand corner. If the insurers have more bargaining leverage because they have alternatives, then you can expect the insurers to pay less, and you will see a smaller number in the bottom right-hand corner.

Q. That's very helpful. Thank you, Dr. Dranove.

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One thing I'm wondering about is if you have all these different services, are they all negotiated at once on a systemwide basis, if you will, by the provider?

A. Yeah. The negotiations take place on a systemwide basis; there is actually some interesting research showing that. In some cases, they could take place across an entire state, so a provider who has locations across an entire state negotiating with an insurer that's -- that has enrollees across the state, again, what they care about is just that one bottom right-hand number, how much money are the providers going to get from the insurer.

Q. Maybe we can make this a little easier to digest if we sort of do this piecemeal. Let's turn to a graphic representation of what you're describing in this selective contracting process.

A. Sure.

Q. Can you just briefly describe what's being shown on this slide?

A. Sure. So this kind of -- this kind of replicates the ideas that I introduced in my research decades ago, now. At a given year, towards the end of the calendar year, you will see the results of what's often been months of negotiations between health plans and providers, which the health plans form networks of providers. They then take those networks and other characteristics of their insurance

1303

plans, and they market them to area employers and the employees who work for them.

If they have attractive features, they have an attractive network, and they have good prices, they will be likely to sign up more enrollees than if they have unattractive networks. Enrollees sign up for their plan, and then, based on their plan, they will almost always choose in-network providers. And when they choose those in-network providers it's pretty much the way it worked 20, 30 years ago, where you had enrollees who were insured, and so they were insulated against prices, and we don't have a lot of transparency, so they couldn't shop around on the basis of price.

So what I call Stage 2 competition was really competition based on other factors, such as the reputation of the provider or the location of the provider. If you're looking for where prices are being determined, it's through the negotiations in Stage 1 competition; that's where we're able to see the discounting and the reductions in prices and the price discipline that was so lacking 20 years ago.

Q. Okay. That's a lot of information, so maybe we can even unpack that a little bit further. And I think what I would like you to do is focus for the moment on the stage 1 bargaining process that you just described.

A. Sure.

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Q. I am bringing up another slide on the big screen here. Can you just describe what this diagram is intended to represent?

A. Sure. So this diagram kind of depicts a health plan in negotiations with St. Luke's. And the health plan in these negotiations is, like any party in a bargaining relationship, thinking, Suppose I walk away from St. Luke's. Or St. Luke's is asking for a certain price, suppose I think that that's too high. What are my alternatives? In this particular situation, I'm imagining the health plan trying to secure primary care physician services for its enrollees in Nampa.

So there its alternatives are several. It's got Saltzer, which, as I mentioned earlier, is the largest provider of primary care services in Nampa. There are primary care physicians who are working for Saint Al's, and there are other primary care physicians as well in the marketplace. And there might be other alternative factors -- this is this box with dots in it, and there's lots of different possibilities, things that the health plan might use to exercise to create an outside option or give itself some leverage out of this negotiating with St. Luke's.

So these are the factors the health plan is considering, and the most important one in terms of the

1305

outcome in the negotiation is if I drop St. Luke's, how viable are these alternatives? Are these -- in Mr. Crouch's words, are these my best -- what are the characteristics and how good are my best alternative options, my BATNA.

Q. Just to be clear, what we're seeing here is that the world, as you would describe it, in Nampa for PCP services before --

A. Before the merger, of course. If Saltzer is an option, then we're talking about before the merger. And I think we're going to see how different it is when they're combined together.

Q. Right. So this is the preacquisition bargaining dynamic. Let's take a look at a diagram showing the postacquisition bargaining dynamic.

A. Well, in the postacquisition bargaining dynamic, as the health plan, if I decide to back away from St. Luke's, the situation isn't so good as it used to be. A lot of my enrollees would have found that their next best option would have been Saltzer. So, sure, I'm denying them their preferred doctors, but at least I can give them their next best option.

But if St. Luke's and Saltzer are negotiating as a unified front, and I now say, what if I drop both of them, well, my best alternative isn't so good anymore, and, in fact, for a large fraction of the people for whom they had

1306

an alternative of seeing their second-best option, so maybe St. Luke's was their preferred doctor, and maybe they would be happy going to Saltzer, they don't even get to see their second-best option anymore. Now they are forced to see their third-best option.

And this is where the bargaining leverage comes in. It's not simply St. Luke's had some leverage, Saltzer had some leverage, and now they bargain together, they have the sum of those two, and they end up getting the same total money. No, the leverage is enhanced. This is kind of superadditive because instead of telling your enrollees, "It's okay, you can still see your second-best option," you now tell them, "You're going to have to see your third-best option." And that's just not attractive for a health plan trying to market that network to people who live in Nampa.

Q. As between these two diagrams, is the only change what you just described? Did anything else change?

A. The only thing that affects the relative leverage of the two parties -- and make no mistake, both parties have some points of leverage at any point in time, but the only thing that affects the relative leverage as a result of the deal is the fact that the enrollees who used to have the opportunity to see their second-most preferred provider are being denied that opportunity if the health plan walks away from St. Luke's and Saltzer, and that enhances St. Luke's

1307

and Saltzer's leverage above what it used to be, and it allows them to get more in that bottom right cell than they were able to get individually. So the bottom right cell gets bigger than the sum of what they used to get individually. Nothing else has changed.

Q. So suppose for a second that the health plan in this scenario is very large. Couldn't they stop this bargaining leverage change that you're talking about?

A. Again, there is leverage for both parties going in, and a large health plan may have some leverage because St. Luke's might be saying, "Suppose we walk away from the deal, maybe we won't be able to get that health plan's enrollees." Although, one might expect that many enrollees might be willing to switch health plans. One doesn't have loyalty to a health plan the way one has to a doctor. But even so, there is some concern on St. Luke's and Saltzer's part about what happens if they walk away from the deal.

But the size of the health plan isn't being affected by this merger. It's the size of the providers. And so the plan's leverage remains the same. And the outcome of the bargain shifts in favor of the providers when the providers merge.

Q. Now, does this dynamic that you're describing apply to all forms of health plan contracts?

A. In principle it can apply to any bargain. What

1308

matters, to a large extent, is how important is that merger. So a merger between two primary care physicians might have some tiny impact, because there might be some patients for whom the second physician was their second-best choice compared to the first physician. But here we're talking about very large players in an important market, and so the magnitude of this merger and the magnitude of the leverage change is going to be much bigger.

Q. You're familiar with the term "fee-for-service," Dr. Dranove?

A. Yes, I am.

Q. Does this type of dynamic apply to fee-for-service contract negotiations?

A. A fee-for-service is where the -- there are rates paid for every service that's provided, and it certainly applies to that dynamic, but it's not limited to fee-for-service. You could have what's known as "risk-based contracting," which is kind of a catch-all term for a lot of other different types of contracts.

For example, you could have something known as a member-per-month contract sometimes called capitation. It became associated with HMOs, but when HMOs became a dirty word people stopped using that term. That's where the provider organization agrees to take a fixed fee per member per month and provide medical care services for all the

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enrollees for that fixed fee. That fixed fee, which would be paid by the insurer or paid, perhaps, directly by the employer, again, it's something that gets negotiated. And if the providers gain leverage, they will be able to negotiate a higher fixed fee, a higher per member per month. So no matter what the form of contracting, leverage is going to work -- leverage as a result of this merger is going to work to the benefit of St. Luke's and Saltzer.

Q. So we've talked about bargaining leverage. Let's take a look at how that bargaining leverage impacts employers and consumers.

A. Sure. But it is pretty straightforward. At the end of the day, employers and their employees are paying the medical bills. So if the providers gain leverage that negotiate higher plans rates, the plans will pay more. The plans will pass that along to their customers, and that means higher premiums, lower wages, and all the bad things that happen to us as individuals when our healthcare spending goes up.

Q. And I see the phrase on the screen "out-of-pocket costs." Can you just explain what that is.

A. Sure. So it's -- in addition to the premiums going up, which employers are paying, and then indirectly employees are paying because it can come out of their wages, if you're making a 10 or 20 percent cost-share payment,

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you're going to be paying a little bit higher because you're paying 10 or 20 percent more of a higher price.

Q. So with that framework in mind, Professor Dranove, let's turn to the analysis you undertook in this case, starting with product market. I'm going to skip ahead here. There is a lot of information on this slide.

A. Yes, there is.

Q. Forgive me. Just at a very high level, can you just explain what "product market" is.

A. Sure. Think of anything you buy as doing something for you. So that Toyota automobile I was talking about provides you convenience and quick transportation in local markets, and we can think of that as something that other products provide. And the market would be defined by the set of products that provide the same what I call "product performance characteristics"; they kind of do the same thing for you. And pricing and other outcomes of competition are basically determined, in part, by who is in the product market. So Toyota and Honda, and, potentially, BMW and Ford and Chrysler, might all be in the same product market. But, perhaps, Trek and other bicycle makers, which also provide transportation -- not really in the same product market, because we wouldn't believe that a reduction in the price of bicycles would have a dramatic impact on the nature of competition between Ford and Toyota and so forth.

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Q. So how do you go about figuring out what the product market is? Is there a test that you use?

A. The economists are guided by the concept of substitutes. Folks whose prices affect what you're able to do as a seller, and if firm -- firms are selling products that are close substitutes will tend to think of them as being in the same market. And the antitrust agencies help develop a very nice way of capturing that in a way that's actually operational, that we could take to the data, known as the "hypothetical monopolist test."

And the nature of the hypothetical monopolist test is as follows: Suppose you have a group of sellers that you believe constitute a well-defined market. And let's think of product market. So you believe that automobiles represents a well-defined market, and you're wondering whether you're being too narrow, that you should include bicycles, as well. The hypothetical monopolist test goes as follows: Suppose that all of the sellers in your hypothetical monopoly were to get together and legally conspire to raise prices by a small but significant amount, and do so for at least a year, a nontransitory increase. And taken together, we get small but significant nontransitory increase in price or SSNIP. So if you hear me referring to SSNIP, you'll know I'm referring to this concept of a group of sellers, collectively, raising their

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price by, say 5 or 10 percent. That's usually the range we talk about for the SSNIP test.

If they could increase their profits by doing so, we would consider that to be a well-defined market, and the rationale is as follows: If they could increase their profits by doing so, that would tell us that not a very large number of customers decides to take their business elsewhere. So suppose bicycles really were a great substitute for cars. So maybe this is Portland, Oregon. I'm told that people like to bike around there. If bicycles really were a good substitute, then if all the carmakers were to raise their price by 5 or 10 percent, then lots of people would say, the heck with a car, I'm going to ride a bicycle. And in that case, we would not have a well-defined market.

Now, I've actually taken to data or asked industry participants whether, in fact, people would move away from cars in droves if the price of cars went up by 5 or 10 percent, but I'm hazarding a guess that they would not, and therefore we would conclude that cars was a well-defined market and bicycles was in a different market.

Q. So with that as backdrop, did you analyze a particular product market in this case?

A. Yes, I did.

Q. And what was that?

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A. Adult primary care physician services. In fact, there is no dispute in this case that adult primary care physician services is a relevant product market, and I think the way to think about this, conceptually, is very simple. Suppose that all the PCPs in the entire United States -- we'll get to geography later -- so all the PCPs in the entire United States got together and told insurers we're going to raise our prices by 5 or 10 percent. Would insurers go to employers and say: Here's the deal, we've got a terrific network for you. There are no PCPs in the network. There are no general practice physicians, no general internal medicine physicians, no PCPs. Health plan is going to have no chance.

Another health plan that does agree to the price increase is going to come in, go to the same employers, and imagine, you know, employees signing up for a health plan where there are no PCPs. They're just not going to buy that product. So, conceptually, we can see that PCPs taken collectively could implement a SSNIP. If we did allow them to collectively raise price, they'd get away with it. They'd make more money by doing so.

Q. I'm going to ask you to sort of suppose for a moment with your recent illness -- I mean, you could have gone to a pulmonologist, potentially, to get a checkup. Why wouldn't that pulmonologist be in your PCP market?

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A. It is true that just because I've defined a market that doesn't mean that everybody who buys services will buy it from people in that market. There could be other sellers who will occasionally sell the same product. So, for example, a cardiologist, maybe I struck up a good, long-term relationship with a cardiologist, and that cardiologist might provide my annual physical. I know there are some cardiologists who do so. That doesn't deny the fact that if I'm an insurer and I go to my customers and I say: You know what, don't worry about getting your primary care. You need primary care, we got cardiologists. You need primary care, we got cancer doctors. You need to have the PCPs. And I think it is well understood by all the people, all the experts in this case, and I think that's why there is no -- there is no dispute that despite the fact that sometimes patients will get primary care from non-PCPs, PCPs are a well-defined product market.

Q. Let's turn to the other piece of the puzzle. We have talked a little bit about the who, again, or the what, if you will. Let's talk about the where. Let's talk about geographic market.

Did you analyze a relevant geographic market in this case?

A. Yes, I did.

Q. And what conclusion, just at a very high level,

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did you reach on that subject?

A. Nampa is a well-defined geographic market, so taken together, PCP services in Nampa is a well-defined product market and geographic market.

Q. So we've talked about this hypothetical monopolist and SSNIPs. How did you go about defining a geographic market in this case?

A. So, again, my goal is to answer this conceptual question: Could all the PCPs in Nampa get away with a collective price increase of 5 to 10 percent? Not just the ones who are in Saltzer and St. Luke's, all the PCPs in Nampa. If, collectively, they went to health plans and said, "We want a price increase of 5 or 10 percent," would the health plans agree? Would they get that outcome from the bargain?

And to answer that question I looked at testimonial evidence, documentary evidence, as well as some statistical evidence.

Q. Let's talk about some of that evidence that you considered in formulating your opinion. First, I'm going to put up some testimony here from a variety of witnesses. I'm not going to ask you to read this. It's rather dense. Just from your perspective, how does this kind of testimony fit into your analysis?

A. So I think it's been well known for a while now,

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both from talking to people in the industry and looking at data, that people prefer to get their medical care close to home, and that's especially true for primary care, and there is just a lot of documentary and testimonial evidence that -- suggesting that people in Nampa are no different from anywhere else. They want to get their primary care close to home.

Q. I'm going to jump ahead to another slide, some additional testimony, this time from St. Luke's and SelectHealth. Again, without reading these aloud, just how does this fit into your analysis?

A. So these are statements from people who are assembling networks. And I think this is really telling, these people assembling networks saying, "If we're going to market our network to employers, we need to have doctors in Nampa." They're kind of acknowledging that without Nampa, there is going to be a hole in the network, a geographic hole, and their product is just not going to be as marketable to employers.

And that's the essence of what we're thinking about with the SSNIP test. If they need to have Nampa in order to market their product, then if all the doctors in Nampa were to get together and ask for a price increase, the insurer, the employers would accede to those wishes. If not, they would have a hole, and they wouldn't be able to

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market their product.

MR. HERRICK: Your Honor, this next slide is AEO. I would just ask that the big screen be darkened, please.

THE COURT: Yes.

BY MR. HERRICK:

Q. Now, Dr. Dranove, your screen should still be functional. And I'm going to ask you not to name any names, either the witness or the health plan we're about to discuss. Can you just tell the court how this -- there we go.

Can you just tell the court how this particular fact pattern fit into your analysis?

A. So there was a health plan that was marketing to employers in the Magic Valley, and the biggest city in the Magic Valley is Twin Falls. And this health plan had very few PCPs within Twin Falls in its network. But they had a very high percentage of PCPs in the rest of the Magic Valley, including in the next closest city of Jerome and other cities. They a have very substantial, a very strong presence in those other markets. And they were unable to do business. The employers just simply would not sign up for their product because of the hole they had in Twin Falls.

This shows that having primary care physicians in the next community over was not enough to give you a viable network. And again, this suggests that these markets are

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very local, that you've got to fill in these holes in order to be able to attract the business of employers. And when thinking about the SSNIP test, that means that if all the people in that hole ask for a price increase, you've got to give it to them.

Q. So -- and that's true even though the Magic Valley is somewhat different from the Treasure Valley?

A. I think it's a general principle. I don't think there is anything unique about Magic Valley, about Twin Falls, about Treasure Valley, about Nampa. If you have a substantial geographic presence like Nampa, with 80,000 people, or Twin Falls, another large population center, it's not going to be enough to have physicians in neighboring communities. You've got to have the physicians in that community.

Q. I'm going to ask you to be very specific here, Professor Dranove. How does that experience, that fact pattern you just described, inform your opinion on whether Nampa is an appropriate geographic market?

A. I think what it basically does is confirm the approach I've taken in thinking about this market and other markets that I've studied in other instances. Healthcare is local. People want their services locally. And this confirms, I think, more vividly than I've seen in other cases where you didn't actually see the holes. In other

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cases, insurers have immediately agreed to the increases. Here it just confirms what happens to insurers who don't agree, who try to go ahead with this hole in their network. They don't succeed.

MR. HERRICK: Your Honor, if you could bring the -- thank you. You anticipated my question.

BY MR. HERRICK:

Q. So we've talked about testimonial evidence. Let's take a look at a document from St. Luke's files. Have you seen this chart before?

A. Yes, I have.

Q. And how does this kind of evidence fit into your analysis of geographic market?

A. You know, I don't want to place too much weight on this or any other slide. This is just one more piece of the puzzle. St. Luke's, itself, in its own planning evidence, was looking at what it called the "Nampa market" to try to understand market share. So in its own, or at least in one of its own, internal calculations it computed market shares, having already, somehow, decided that Nampa would be an appropriate venue for doing so.

Q. You mentioned that this was just one piece of evidence. Did you consider other evidence before forming your opinion?

A. Yes. So we've already talked about a lot of the

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testimonial evidence. I also looked at a lot of data to help form the opinion.

Q. All right. You anticipated my next question.

I put up on the big screen a table labeled, "Location of PCPs Chosen by Nampa Residents." And I would just ask you to explain for the court what this table is intended to show.

A. Sure. So the table is taken from data from insurers who provide information on where their enrollees live and which providers their enrollees visit and were able to identify where the providers are located. And we learned that for Nampa residents, 36 plus 31 or 67 percent, 68 percent, a little over two-thirds, is the first two bars, get their primary care physician services from providers who are located in Nampa. Another 16 percent, which gets us up to about five out of six, go to Nampa or to a Nampa-adjacent zip code. The rest go elsewhere. It doesn't necessarily mean that they're actually traveling to get their primary care physician services. A lot of the ones who are going elsewhere are getting their physician services near where they work. So, again, they are looking for convenient providers. And this is basically confirming that patients like to get their medical care close to home.

Q. Where does Boise fit into this chart?

A. Boise is in part of the 15.7 percent. And a

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pretty good percentage of the Nampa residents who are getting their care in Boise are actually people -- residents who work in Boise.

Q. So how does this data factor into your analysis?

A. It's just one more piece of the puzzle. It's just one more consistent piece of evidence.

Q. Let's turn to another slide showing some travel patterns, if you will.

A. My Pac-Man slide.

Q. The Pac-Man slide. Just if you could very briefly explain what this slide is intended to show.

A. Sure. So what this slide does is it takes a look at a lot of different zip codes. And for each zip code it shows a pie chart where each slice of the pie, sometimes way bigger than a slice, represents the location of primary care physicians that were visited by people who were in that zip code.

And there was actually a rather stunning kind of bifurcation. You can't quite see it on the slide, but if you do a dividing line, dividing Ada County on the east and Canyon County on the west, you would see that on the east the pie charts are overwhelmingly yellow and orange, which basically represents patients in Boise and Meridian tend to go to doctors in Boise and Meridian; and if you go to the west, the charts are overwhelmingly purple, with one

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exception. There's one zip code right on the border -- you can probably see the one that I'm talking about, just above the Interstate 84 -- it's 84, isn't it?

Q. Yes.

A. It's an 84 shield -- where a lot of those enrollees are going to Meridian and some of those are going to Boise.

But this kind of shows that there's this split, patients who live in Canyon County get their medical care in Canyon County, and patients who live in Ada County get their medical care in Ada County. It's not perfect. And, in fact, there is no particular threshold that one really should look for. And, in fact, it's rather dangerous to say how big should the slices of the pie be before you reach a conclusion. These are just all bits of evidence that are all consistent, all pointing in the same direction.

Q. So just so I'm clear, does this analysis and the one on the slide before, does that rely on patient flow data?

A. It does use what's called "patient flow data," which is an examination of where patients go for their medical care, usually using zip codes because that's what's in the available data.

Q. Is that somehow -- well, let me back up.

Have you heard the phrase "patient flow analysis"?

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A. Yes, I have, and that's different from patient flow data. It uses patient flow data in a very specific way by claiming, I think incorrectly, that there are clear thresholds, that if the percentages exceed a certain number or if the sizes of the pie slices exceed a certain size, then that's it. Based on that, you've defined your geographic market. And that's not what I've done.

Q. Based on this patient flow data, as well as the other evidence we've talked about, how does this particular piece of the puzzle, if you will, fit into the bigger picture?

A. You know, the big picture is -- we've already seen it from the testimonial evidence -- that you need to have docs in Nampa or you're going to have a big hole in your market. If there is a big hole in your network -- if there is a big hole in your network, as an insurer, you're not going to be able to market to employers, which informs the SSNIP, which tells us that Nampa is a well-defined market. And the insurers have good reason to think this because the data shows us that, indeed, patients don't like to travel.

Q. Well, defendants, as you're aware, contend that patient flow data suggests that the geographic market should be much bigger than just Nampa. Did you take that into account in your analysis?

A. Patients will travel for medical care. But to

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inform the SSNIP, I have to think about how these contract negotiations are going to work. And if I see patients traveling, that really doesn't tell me much about the -- well, it's not definitive about negotiations. There are lots of reasons why patients travel that are not going to be informative for the SSNIP.

We talked about the fact that patients might work in Boise. And it doesn't do me much good as an insurer to go to employers and say, you know, I'm not going to have any doctors in Nampa, but don't worry, if you want to have a convenient PCP, just get a job in Boise, like the other folks in Nampa who are seeing doctors in Boise. If you don't want to travel, that's the way to do it. That's going to be silly.

So the fact that you see some patients traveling, say they are traveling to Boise because they want a doc near where they work, that's not informative for what's going to happen during these negotiations. You're going to have a hole in Nampa for all of the individuals who don't work in Boise or didn't move from Boise and still have a relationship. There are large numbers of people in Nampa who want to see a Nampa doc, and the fact that some people in Nampa travel to Boise for care is not informative about those negotiations.

In a recent antitrust case, Ken Elzinga, who

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introduced this notion of looking at patient flows and called this the silent majority fallacy --

MR. STEIN: Objection. Hearsay. Dr. Dranove is going to testify about what somebody else, purportedly, testified to in another case.

THE COURT: Well, if the witness relied upon it, I'll allow it.

THE WITNESS: It's in my expert report.

THE COURT: The objection is overruled.

THE WITNESS: And he basically made the same point: The fact that some patients travel for care doesn't tell you what the majority of patients chose not to travel will feel if they look at a network and they see it doesn't have local providers.

BY MR. HERRICK:

Q. You mentioned Professor Elzinga. Did he formulate any kind of test for this type of analysis you're referring to?

A. So he developed a test that's a variant of this patient -- patient flow analysis using patient flow data. And there have been various variations of that type of patient flow analysis that people have used to try to do geographic market definition. And he concluded that that was not appropriate to do for defining healthcare markets.

Q. And does that test have a --

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THE COURT: I would like to ask one question. It strikes me that what you have talked about in terms of -- was the term "select contracting"?

THE WITNESS: Yes.

THE COURT: -- and the advent of, I guess, incentivization of employer programs and wide networks, narrow networks, that perhaps there is a change afoot in the consumer expectation, that perhaps that may be changing. Is that accurate or -- and if it is changing, is that a trend that is likely to be accelerated with the Affordable Care Act and other -- do you have --

THE WITNESS: Those are good questions, and I have thought a lot about that. There has been a lot of talk about narrow networks, and we are seeing the introduction of some narrow networks through the exchanges. The exchanges are going to be limited, largely, to individuals buying their healthcare. Employers have not embraced narrow networks, because employers can't just appeal to one or two employees who might be willing to sign up for the narrow network. They've got to offer a plan that appeals to all of their employees. And so narrow networks are still very slow in getting a toehold in the large healthcare marketplace.

THE COURT: Is that changing the consumer expectation? Even though the insurance companies and the plans are the ones driving the negotiation, their ability to

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market to the consumer or to the employer has to, I guess, inform their -- or not inform, but affect their negotiation. So is there any change with the consumer afoot, in terms of their willingness to look at traveling to Boise from Nampa?

THE WITNESS: Sure. So say that would be the situation here, that the employer told them, we'll give you a really good deal if you don't get any primary care in Nampa, if you agreed to go to Boise, right?

THE COURT: I guess what I'm getting at is just, generally, perhaps a change in attitude because of the change in our understanding of what is -- what our healthcare can and must -- how it can and must change.

THE WITNESS: Sure. Well, they often say that trends in healthcare begin in California. And there was a recent study of narrow networks that was published in the journal *Health Affairs*, in California, showing they are having a very difficult time getting a toehold even there. I wouldn't doubt that down the road we might revisit this in five or ten years, but it's not happening.

THE COURT: Not today.

THE WITNESS: Not today.

THE COURT: I'm sorry. Mr. Herrick.

BY MR. HERRICK:

Q. This is actually a very interesting topic for me, too, Professor Dranove. We talked a lot, several slides

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ago, about the dynamic of selective contracting and the changes in leverage and so forth. Do those same dynamics that we talked about then apply to the advent of narrow networks?

A. Yeah. So we think of narrow networks, we are often seeing now these different tiers of networks, and so you're often seeing employers or insurers trying to create a second tier, which is a narrower network. So, for example, perhaps the employees will only have to pay 10 percent if they go to the providers in the most preferred tier. But perhaps they will pay 20 or 30 percent if they go to providers in the second-best tier, and then if they go out of network they're on their own or they have to pay for half or something like that, just dramatic increases in prices. I thought it was very interesting when I was reading, I think it was Mr. Otte, talking about --

Q. I would just caution you not to reveal any "attorneys' eyes only" information during this answer. I'm sorry to cut you off.

A. Okay. So just in general, a provider who gains power, has bargaining leverage, can exert their leverage not just to command higher prices to be in the best tier, they could command higher prices to be in the second tier, or they can even say we're not going to be in anything except for the best tier, take it or leave it.

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And so your ability to create a narrow network, now might instead be creating essentially a, virtually, nonnetwork with almost no providers in the network. And so powerful providers have the ability to influence what happens going forward even if we start to see the emergence of narrow networks.

Q. Thank you for that.

We've talked about patients traveling for PCP services. If some patients do travel for PCP services, how does that affect the way health plans might construct their networks?

A. Well, I think if you were a health plan and you're trying to construct a network, I think your goal is to make sure that you keep these networks convenient for your enrollees.

What you see on this pie chart are kind of a summary of what these plans look like in terms of the geographic representation. So BCI, Blue Cross of Idaho, it turns out that in the most recent network that I looked at for Blue Cross of Idaho, there were PCPs under contract in every zip code where they had enrollees. They did not require a single enrollee to travel outside of their zip code.

PacificSource, 3 percent of enrollees would have to go to a provider out of their zip code if they wanted to remain in network. There is a another piece of evidence

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consistent with the simple story that you have to have local access before employers are going to be able to sign you up.

Q. Okay. I'm going to ask you to imagine a different scenario than what we see on this pie chart that's up on the big screen. And not to pick on BCI, but you mentioned them. Suppose BCI was unable to contract for PCP services in Nampa. What -- what do you think the BCI pie chart might look like?

A. Oh, well, there is 80,000 people who live in Nampa as a non -- that's a pretty big percentage of the Treasure Valley total population, well over 10 percent I believe, and -- or roughly that order of magnitude. So suddenly you're talking about a big blue-shaded area.

But I think more to the point, it might not turn out to be such a big blue-shaded area, because I suspect that employers who have employees in Nampa are simply not going to do business with BCI, and so all of the BCI Nampa business will be shifted to one of the other two pie charts, and we might not see a BCI pie chart at all that's relevant to Nampa.

Q. So again, not to pick on BCI, but what do you think that would do to BCI's ability to negotiate with a provider that controlled all of the PCPs in Nampa?

A. Of course it's going to have to accede to their demands for a price increase if that's what they demand.

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Q. So as we talked about a few minutes ago, defendants suggest that the geographic market is much broader than Nampa. Did you evaluate defendants' experts' geographic market analysis?

A. To the extent that I could make some sense as to how he was defining the geographic market, I did take a look at it, yes.

Q. This slide references Dr. Argue. Is that defendants' expert on this particular topic, as you understand it?

A. Yeah, as far as I understand, he never states what the geographic market is; however, he does believe that it's much bigger than Nampa, including, at least, Nampa, Caldwell, Meridian, and west Boise. I don't believe that that claim is going to stand up to scrutiny. In fact, it relies entirely on patient flow analysis, which is the single-minded approach of taking a look at percentages and concluding that the percentage flows exceed a certain number or less than a certain number, and therefore I don't have a market or therefore I do have a market, an approach that's been discredited by both economic theory and economic empirical research.

Q. So we have been focusing our discussion primarily on Nampa thus far. Are your conclusions about geographic market strictly limited to a Nampa geographic market?

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A. No. Although I think Nampa is the correct market, I also considered the possibility that maybe insurers would be willing to go to bat with a Nampa-Caldwell. If we didn't have Nampa, well, at least we'll have Caldwell. Or if we don't have Nampa, at least we'll have Caldwell and Meridian. So I expanded the geographic market, and I -- in terms of the conclusions I'm going to reach later about market shares and the potential anticompetitive impacts, my conclusions are the same.

This chart, I think it's actually really cool because it points to the dangers of relying on patient flow statistics to reach market conclusions about market definition.

I mentioned that patient flow analysis looks at specific flow numbers in saying if the percentage of people who are traveling exceeds a certain number, then you don't have a well-defined market, you have to expand the market. So Dr. Argue has looked at the 38.1 percent figure, which is the percentage of the Nampa residents who get their primary care out of Nampa, and concluded that the market definition needs to be expanded. And he continues to go out in a market or a potential market that he alludes to would be one that includes Nampa, Caldwell, Meridian and west Boise.

Well, if you consider that as a potential market -- I'm not saying he concludes that it is or isn't

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the market, he certainly gets at least that far -- but if you think that might be the relevant market, well, I put up on the slide the flows out of Nampa, Caldwell, Meridian, and west Boise. And that's even higher than the flows out of Nampa, which would lead, inexorably, to the following kind of line of arguments.

Well, if 38.1 percent is so big that Nampa is not a market, then 38.6 is even bigger. So Nampa, Caldwell, Meridian, west Boise, that's not a market, which means that if we were to implement the SSNIP test for Nampa, Caldwell, Meridian, west Boise -- let me restate that.

If all the primary care physicians running from Caldwell on the west -- I don't know which way west is -- Caldwell on the west -- all the way up to west Boise and all the primary care physicians in between were to go to an insurer and say, we're going to have -- we want a 10 percent price increase, and somehow we're supposed to believe that the insurer is going to say, nope, I don't need you, I can market my health plan to all the residents of the Treasure Valley without any primary care doctors between Caldwell and west Boise, that just doesn't make any sense to me.

And so to say 38.1 percent, that means you're not a market, well, that means 38.6 percent you're not a market. But of course all of those doctors together, if they were to

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collectively ask for a price increase, would get it, which shows that patient flow analysis relying on thresholds just leads to inappropriate conclusions, and that's just not the way to define a market.

Q. So we've talked a lot about evidence on geographic --

THE COURT: I hate to do this, but could you explain how the outflow percentage, the 38.1 percent, what does that actually represent?

THE WITNESS: That shows if you take all the people who live in this geographic area and ask what fraction of them are getting their care from some provider outside the area.

THE COURT: Outside.

THE WITNESS: So a large part of this is the fact that a lot of residents of west Boise are going to go see doctors in east Boise, and that's contributing to the high outflows.

THE COURT: All right. Thank you.

Go ahead.

BY MR. HERRICK:

Q. Just to be clear, Professor Dranove, the calculations on this chart, are those your calculations or Dr. Argue's?

A. These are Dr. Argue's percentages, but they are

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drawn from the same data. I don't dispute the percentages.

And just to follow up, I mean, it may be that some residents or many residents of west Boise get their care from east Boise. But for the SSNIP test we have to go back to the negotiation. Again, you can't -- the insurer can't go to the employer and say, it's okay if we don't have any PCPs between Caldwell and east Boise -- I'm sorry, between Caldwell and west Boise because a lot of the west Boise residents go to east Boise for their primary care. There aren't very many employers who are going to say, oh, that's going to be -- that's going to be comfortable -- that's going to be comforting to all of my employees who live in Nampa and Caldwell and Meridian. It's just not going to work. They are not going to be able to market that network.

Q. Okay. We talked a lot about evidence on geographic market data, testimony, and so forth. Let's turn to market shares and competitive effects.

A. Sure.

Q. Did you reach any conclusions on market shares and competitive effects in this case?

A. Yes. I believe that the merger will lead to a substantial increase in market share, an increase that's consistent with a long history of economic theory and empirical research of kind of potentially harmful effects of the merger.

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Q. And what kinds of evidence did you consider in this part of your analysis?

A. I -- based on my market definition, I computed market shares based on a number of different ways one can measure market shares. I looked at those market shares in comparison with guidelines that have been developed in conjunction with both the antitrust agencies and academic economists. I also looked at what the folks involved in these markets are saying about the potential anticompetitive impact of the merger. And then, lastly, I augmented this with a more nuanced look at substitution patterns between providers, known as "diversion analysis."

Q. So you mentioned some thresholds. I have put up on the big screen a summary of some thresholds. Can you just briefly describe for the court what these thresholds are and how they fit into your analysis?

A. So the "HHI" stands for the "Herfindahl-Hirschman Index," which is why I'll call it the "HHI." It's a number that's calculated based on market shares. It could range anywhere from zero, which would be like having infinitely many tiny providers, all the way up to 10,000, which would be one pure monopolist, and it could range anywhere in between.

And based on a long history of economic research about how price competition plays out in a wide variety of

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markets, the antitrust agencies have established some thresholds for HHIs that are potentially anticompetitive or presumptively anticompetitive. And the one that's highlighted here is HHI over 2500 on this 10,000 scale. That would be an indication the market is highly concentrated. And then a change in the HHI, how much more concentrated did it become as a result of the merger, of 200 points or higher.

And those are just thresholds. They're not hard and fast rules, so one would want to examine, you know, how far are you from the threshold, and if you're close to the threshold, what do the other facts on the ground say. If you're far from the threshold, you still want to look at the other facts on the ground, but maybe this evidence by itself is already very strong.

Q. So are you required to follow the merger guidelines thresholds?

A. I'm not required to do so, but they have been developed in conjunction with leading academic economists with much history behind them, so I think it's a good thing to do. I think it's a very good approach to looking at market concentration.

THE COURT: Counsel, just one other -- this is almost a silly question. My understanding is that the HHI guideline is basically market share squared.

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THE WITNESS: Yeah, so the --
THE COURT: And why? I don't understand, unless someone is just trying to make it look a little sexier than what it really is.
THE WITNESS: So the Herfindahl-Hirschman Index is computed by taking each firm's market share, squaring it, and summing it up.
THE COURT: Okay.
THE WITNESS: There are other ways of computing market concentration. A popular one is known as the four-firm concentration index, and that simply is what percentage of the market is controlled by the four biggest firms. One weakness of the four-firm index is that it doesn't distinguish between a market with four firms at each of 25 percent market share and a market where you have one firm with 70 percent share and three firms with 10 percent share; you'd get the same four-firm index.
THE COURT: But the idea is that this will kind of enhance the apparent effect of the concentration of market power?
THE WITNESS: Yes. This one -- if a firm that -- and economic theory shows you that markets are -- it's much more likely to see prices increase in a market where you have one firm with 70 percent versus a market with four firms with 25 percent. So this index captures that.

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BY MR. HERRICK:
Q. And just to clarify, do these thresholds apply to healthcare markets?
A. Yeah. They have been applied in a wide variety of settings. They are not specific to any particular setting.
Q. All right. So let's take a look at your calculations of market shares and HHIs in this case. I've put up on the big screen a market share pie chart. Can you just briefly describe what this is intended to show?
A. Sure. So there are a variety of ways in computing market shares. We try to have some measure of the intensity of the business that's being done, so you could use sales revenues. In this case, this particular slide is based on visits, but I did it using something called "relative value units," which is another measure of intensity, and I reached similar conclusions.
And based on visits to PCPs, we see that Saltzer is -- as I think it was KPMG said -- the dominant provider in the market. There are two moderately sized competitors, St. Luke's and Saint Al's, and then a number of smaller competitors.
Q. Let's take a look at how this translates into HHIs, as we were just discussing. Can you just explain to the court what is represented on this slide?
A. Sure. So if you look at the first column, it

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lists the names of the providers; the second column, it's the visits to the providers; the third is their market shares, the percentage of visits going to each provider before the merger; and then a little bit of hand-waving, the squaring of the market shares and the summing them up, and then multiplying by 10,000 so that we don't have to work with fractions, gives us the HHI of 4612. That's the premerger HHI.
After the merger we have a new single entity Saltzer-St. Luke's combined. Their combined market share is now 77.7. When we redo the calculations, we get a bigger postmerger HHI of 6219, for a delta of 1607, which is just 6219 minus 4612. If you don't mind going back I think a slide or two where it shows the merger guidelines, let me see if I can pick out a couple numbers.
Q. There we go.
A. So presumptively anticompetitive is the postmerger HHI over 2500. We're now more than double that. And that HHI increase of over 200 points -- I can't remember if it's sixfold, more than six times that -- if you want to come forward two slides.
Q. You are testing my technical capabilities here.
A. Yeah. I think it's eight -- it's over seven times that. So we are nowhere close to the thresholds. We are well above the thresholds for a presumptively

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anticompetitive merger.
Q. So what does this suggest to you about the market that you've defined?
A. That's a highly concentrated market where there is some competition today, and it's going to be greatly reduced as a result of the merger.
Q. Now, as we've discussed, defendants have suggested that the market is much broader than just Nampa. Did you consider alternative potential geographic markets as part of your analysis?
A. Yes, I did. I allowed for the possibility that insurers would believe that even if they didn't have Nampa, they could have a viable product if they included Caldwell. And so I expand -- so then the SSNIP test would say Nampa-Caldwell was the market, and I recomputed market shares for the Nampa-Caldwell market. You can see the shares here. The shares are different.
But the conclusions in terms of where you are relative to the merger guideline thresholds are largely the same. You're not twice the merger guideline thresholds, but you're still well above the merger guideline thresholds. The change in the Herfindahl Index as a result of the merger is still well above the threshold change. I also did the same thing for Nampa-Caldwell-Meridian, allowing the market to be even bigger.

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Q. So just focusing on Nampa-Caldwell as a potential alternative market for the moment, just so I'm clear, is it your testimony that the acquisition would still be presumptively anticompetitive if you were to expand the market to include both Nampa and Caldwell?

A. Yes, it is.

Q. All right. So you mentioned Nampa-Caldwell-Meridian as a potential alternative market. Let's take a look at that. Can you just walk the court through your analysis here.

A. Sure. Again, the numbers change, but the conclusions don't. You have a market that's highly concentrated to begin with, and the merger greatly increases the degree of market concentration well above the thresholds of the merger guidelines.

Q. Again, just so I have it straight, is it your testimony that the acquisition would still be presumptively anticompetitive even if you expanded not only to include Nampa and Caldwell but also added Meridian into the mix?

A. Yes, it is.

MR. HERRICK: Your Honor, we are now moving into some AEO territory, and I would request that --

THE COURT: In terms of testimony or just the --

MR. HERRICK: And the slides.

THE COURT: All right. So we will need to clear

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the courtroom?

MR. HERRICK: Yes, Your Honor.

THE COURT: I think, without exception, we'll just have everyone leave unless there is an agreement that one party's clients can stay or representatives can stay.

MR. HERRICK: I think this falls into the strict AEO category, so it involves some third parties.

THE COURT: I'll ask everyone to leave the courtroom unless you're an attorney that's been advised you can stay.

****** COURTROOM CLOSED TO THE PUBLIC ******

MR. HERRICK: I think we're ready to proceed, Your Honor.

THE COURT: Yes, Mr. Herrick.

BY MR. HERRICK:

Q. So we've talked about market shares and presumptions. Did your analysis stop there, Professor Dranove?

A. No. I also looked at testimonial evidence and another more nuanced approach of looking at substitution patterns called "diversion analysis."

Q. And typically, is it sort of a two-step process in your analysis where you first look at the market shares in HHIs, and then you look at evidence of anticompetitive effects?

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A. I don't think they come in any sequence.

Q. Okay.

A. They're both relevant.

Q. All right. Well, let's look at some of that other evidence you just alluded to. First, let's take a look at some testimony.

A. Sure.

Q. I have put up on the big screen -- and just as background here, did you review testimony as part of your analysis of competitive effects?

A. Yes, I did.

Q. And I'll just direct your attention to the very first bullet there, some testimony from Dr. Page. Can you just explain to the court how that kind of testimony fits in?

A. Sure. We talked about how in the negotiation before the merger each party has a certain amount of leverage that leads to a certain outcome. And here we have Dr. Page from Saltzer talking about the fact that after the merger, apparently, they think they might be able to get better terms. They're going to reopen those contract negotiations. Why? Because they're going to have the clout of the entire network. I'm not a mindreader. I don't know exactly what this means, but it's certainly consistent with the idea that the merger is going to enhance St.

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Luke's-Saltzer's bargaining leverage.

Q. And did you review any trial testimony in preparation for your testimony today?

A. Yes, I did.

Q. And I'll just direct your attention to the second bullet, some testimony from Mr. Otte. Can you explain to the court how Mr. Otte's testimony fit into your analysis.

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Q. So the fact that Micron has put its health plan -- plans on hold, as an economist, what does that kind of behavior suggest to you?

A. Well, you know, they were able to achieve a certain bargaining outcome when St. Luke's and Saltzer were independent. If this merger goes through and they could bargain as a single entity, perhaps, they don't think they're going to get the same type of health plan that they had before, and perhaps they are concerned about continuing

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to offer the same product.

Q. Can you draw any inferences about at least Micron's perspective on its outside option or its BATNA from this behavior?

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Q. So we have listed a few examples here of record evidence. Was that the only record evidence you considered in forming your opinions about competitive effects?

A. No, it's not.

Q. So earlier we talked a little bit about this bottom right-hand corner of the spreadsheet. And maybe we can try to put that into a little bit of context --

A. Sure.

Q. -- by talking about the ways that might play out here. I'm going to put up on the big screen another slide. If you could just talk a little bit about the ways in which St. Luke's might be able to exercise its market power.

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A. There -- again, it's this big spreadsheet of all these services and all these prices. At the end of the day, the bargainers care about that bottom right-hand cell. St. Luke's, after the merger, if it enhances its leverage, will extract more money through that bottom right-hand cell.

There is a lot of ways that could happen. It could simply negotiate higher prices across the board, or it could start moving patients from some settings where services are provided at one negotiated rate to other settings where exactly the same services are provided at higher negotiated rates. Or it could start doing what's known as hospital-based billing, where you actually don't even change the site where the service is taking place. It's exactly the same site, and you achieve higher billing rates because of the way in which the contracts read. Many other possibilities.

What I thought was interesting was that St. Luke's actually did a projection of how much it thought it would gain from hospital-based billing. And they thought that hospital-based billing, alone, could generate an extra $750,000 in that bottom right-hand cell.

Now, in the near term, you know, before the next contract negotiation, they are just taking advantage of loose wording in a contract; the insurers didn't write into the contract if you acquire somebody we're not going to let

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you do this.

But if they get marketing leverage and this is the way they choose to exercise it, then in the next contract negotiation, the payors are going to have to accept this, and this will be locked in place, etched in stone for future contracts, and it will drive up healthcare spending permanently. But, again, if they don't do it this way, they are going to gain leverage from this merger. If they don't do it this way, they'll do it some other way.

Q. Is it your understanding that this kind of term would be subject to negotiations in future contract negotiations?

A. Sure. Everything is up for grabs in contract negotiations.

Q. And so am I understanding your testimony correctly that the question is whether St. Luke's, in this instance, would be able to make this kind of increase stick?

A. Yes, whether they could make it stick. St. Luke's could establish their own physician practice in Nampa. They could start a physician practice tomorrow there. They could have that physician bill for services through provider-based billing. You don't need an acquisition. You don't need an enhancement in market power.

But if they don't gain any further market power between now and the next contract negotiation, that's going

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to mean a bigger right-hand cell than they were getting beforehand and because they haven't enhanced their market power any, they are not going to get away with it. But if they can enhance their market power through further acquisitions, like Saltzer, they will be able, to use your terminology, make it stick.

Q. Thank you. And you used the term "provider-based billing." And earlier I think you used the term "hospital-based billing." Without getting too technical here, do you have an understanding of whether provider-based billing applies in the Medicare context or commercial?

A. Yes. Provider-based billing is the term used for similar phenomenon under Medicare where prices are not set by negotiation. I wouldn't consider the presence of provider-based billing to be evidence one way or another on market power because Medicare is a regulated system.

Q. So we talked about testimony. And we've talked about documents. What about data? Did you perform any empirical data analysis to assess the acquisition's likely competitive effects?

A. Well, we've already talked a lot about my market share analysis. But I did one more nuanced analysis known as "diversion analysis." And diversion analysis speaks to a potential weakness in market share analysis that might lead you to incorrectly conclude that a merger was

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anticompetitive based solely on the shares.

And the best way to describe diversion analysis is to come back to my automobile markets. And suppose that there were only four automobile manufacturers; let's suppose they were Honda, Toyota, General Motors, and BMW. And we concluded that that was a market; we ruled out bicycles, cars is the market. The geographic market, say, is the United States. And we documented that these four sellers each had a 25 percent market share. Based on the merger guidelines, if you did the calculations, you would get an HHI of 2500, which is right on the borderline. And suppose that two of those parties were going to merge, you would get an increase in the HHI that was above the borderline. So there would be some concern.

Well, if you just used the market shares, you would be just as concerned about a merger between Honda and Toyota as you would a merger between Honda and BMW. But it's not obvious that those would have equal effects on competition in the market. There are probably a lot of customers who were thinking of buying a Honda for whom Toyota is their next most attractive option. And the merger will mean that if prices go up and they don't want to live with it, they are going to have to go to the third-most-attractive option, which means that the merger price increase might stick.

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On the other hand, if it was a merger between Honda and BMW, and they raised price, the customer who wanted to buy the Honda will say, "I don't care, I'll buy the Toyota." And so diversion analysis identifies which firms most closely substitute for one another. And as a result of that analysis, we can come up with a more refined understanding of competition than if we were to just look at the market shares.

Q. Now, you've talked about cars and bicycles. Does this diversion analysis also apply in the healthcare world?

A. Of course. Again, it's a general concept of substitution.

Q. Okay. Well, let's turn to your diversion analysis in this case. I have put up a chart on the big screen here. Can you just describe what's being shown here?

A. Sure. And before I go through the numbers, let me caution anybody who is looking at this, just as in patient flow analysis, there are no thresholds, there's no percentage that says, "because I see a certain percentage I reach a conclusion." What we're learning here is substitution patterns, which are relative numbers.

And what we're learning here is that if St. Luke's was not available in Nampa, where would those patients go? What's their second-most-attractive option? And based on the modeling that I did, I concluded that Saltzer represents

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the second-most-attractive option to St. Luke's patients, which means that Saltzer is St. Luke's closest competitor in this market.

Q. Okay. So this shows diversion, if you will.

A. That's -- so the diversion is 50 percent. I don't want to get hung up on the technical details. I think, again, the relative values. I think an important implication here is that, by my estimate, if St. Luke's patients could not get to see Saltzer patients, then half of those patients would end up having to see their third-most-preferred option. You would be forcing those individuals not just to their second-best choice, but their third-best choice, which gets back to the dynamic of bargaining leverage which I introduced at the start of my testimony.

Q. I think you may have misspoke. I think you said "Saltzer patients." Did you mean "Saltzer physicians"?

A. Yeah, they would be able to see Saltzer physicians. Sorry.

Q. Thank you. So this shows diversions away from St. Luke's, if you will. Did you perform a similar analysis for Saltzer?

A. Yes, I did. It's on the next slide.

Q. There we go.

A. And, again, you can see that St. Luke's is

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Saltzer's next closest competitor. I estimate that a little more than a third of the patients who would have wanted to go to Saltzer, if they couldn't go to either Saltzer or St. Luke's, would be forced to see their third-most-preferred provider, which, again, would make that network very unattractive if it lacked both Saltzer and St. Luke's.

Q. Now, I just want to direct your attention to the third bar from the left that reads, "St. Luke's non-Nampa. So does this suggest that some of the diversions from St. Luke's in Nampa would go to St. Luke's outside of Nampa?

A. Yeah, so, in fact, not -- if you -- if you excluded both St. Luke's and Saltzer, it's not just the 36 percent or so who would not be able to see their second-most-attractive provider in Nampa. There is another 7 percent who are not going to see their second-most-attractive provider from St. Luke's elsewhere. So we are actually now talking about over 40 percent in total of those residents who are not going to get to see even their second-most-preferred provider.

Q. So what does this analysis suggest to you about the competition that's being eliminated by the acquisition?

A. So, what I was looking for here was, you know, a little bit of nervousness, maybe that market share analysis that I did was a little too pessimistic about the

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anticompetitive effects of the merger. Maybe St. Luke's and Saltzer are not deemed to be close competitors in the eyes of patients, and we shouldn't be as concerned, but in fact they're each other's closest substitutes, which just reenforces my concern about the merger.

Q. I just want to put this into context based on our very early discussion today. So what does this analysis suggest to you about health plans' outside options after the merger?

A. Well, the best outside option that a health plan would have before the merger, if it was negotiating with Saltzer, was St. Luke's. The best outside option for a health plan negotiating with St. Luke's was Saltzer. This merger has taken away each health plan's BATNA, best available outside option.

Q. Now, you said that -- you mentioned market shares in this context. Is this the same type of analysis as market shares?

A. This is not a market share analysis. It should not be confused with such. It's specifically for the purposes of identifying substitution patterns.

Q. And is this type of analysis sensitive to a specific geographic market?

A. No. In fact, one of the beauties of this analysis is that you could actually put in any market definition you

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want to start with, and you can still learn about substitution patterns.

Q. Professor Dranove, we've talked about quite a bit of evidence relating to geographic market, market shares, competitive effects. I want to shift to a slightly different topic, and that's Micron.

A. Sure.

Q. I'm going to bring up a slide relating to Micron. As we've already talked about, you did look at Dr. Argue's analysis. Can you just, I guess, put that into context and how you look at Micron.

A. Sure. I think there's two things that I think it's important to take away from the Micron experience. The first is that it's not surprising that a dominant seller -- and St. Luke's has been described as a dominant seller -- or like any firm that has market power will raise price to the point where some customer or customers walk away from it. In fact, economic theory tells us that even the most powerful firms will raise their price to the point where some customers balk because if nobody balks, they should just raise their price further. At some point they are going to make some customers skittish. And so the fact that one or a few firms decided not to include St. Luke's in its network is not surprising.

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Q. So you mentioned "tiers." During Mr. Otte's testimony, did -- did you consider any testimony on that particular topic?

A. Sure. I mentioned earlier that powerful providers can exercise their power in a number of ways. They could say we don't want to be in anything but the best tier. This is our price, take it or leave it. And so I was -- it was

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kind of interesting to see Mr. Otte comment that when they offered it to St. Luke's, of being in the second tier, the PPO tier, if I got it right, St. Luke's responded "We're not in a second tier for anybody," or words to that effect. They simply refused to be in the second tier. And this is a way that a powerful provider can defeat tiering.

Q. Does Micron have any unique characteristics that factored into your analysis?

A. So I mentioned that you will see even when you have a powerful provider, some customers potentially balking at their prices. It wasn't surprising to me that Micron was the exemplar of this. Micron was in an industry undergoing an upheaval with production being shifted overseas. They make chips, and it's a commodity product, so it has very fierce price competition. Their financial outlook was dire, and so employees might be more willing to accept cuts to their benefits because the alternative might be losing the job. And Micron also has an on-site primary care facility, which dramatically reduces the need for enrollees to travel for their primary care if they were to drop, say, the Nampa doctors from their market. They can give them those primary care providers at their place of work.

These are all characteristics that are very different, if not unique, and set Micron apart from other employers.

Q. So would you expect other employers to follow in Micron's footsteps?

A. You know, and I was thinking of who would be on the laundry list of employers that might be willing to sacrifice healthcare benefits in order to save money, and maybe who would be the next to balk. One that came to mind was Walmart. And now I see that the Walmart may be going down the same route. Again, powerful sellers are going to drive some customers from the market. That doesn't mean that they lack power; in fact, it just means they are exercising their power in the way we would expect.

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MR. HERRICK: Your Honor, I believe we are shifting into sort of a middle ground here where St. Luke's counsel could return to the courtroom, but we would still keep it generally closed, if that's okay with St. Luke's.

THE COURT: All right. We are going to take a

recess in about three minutes.

MR. HERRICK: Okay. Maybe now is a good time if --

THE COURT: Why don't we take the recess now, and you can kind of make sure we have the right cast of characters in the courtroom when we resume.

All right. We will be in recess for 15 minutes.

MR. HERRICK: Thank you, Your Honor.

(Recess.)

****** COURTROOM REMAINS CLOSED TO THE PUBLIC ******

THE COURT: Is it Dr. Dranove?

THE WITNESS: Dranove, yes.

THE COURT: I apologize for not getting your name right. Dr. Dranove, I'll remind you you are still under oath.

With that, Mr. Herrick, you may resume your examination of the witness.

MR. HERRICK: Thank you, Your Honor.

BY MR. HERRICK:

Q. Professor Dranove, we talked about the presumption of anticompetitive harm and the qualitative and quantitative evidence that you found to support your conclusion that the acquisition is likely to be anticompetitive. Let's talk about the factors that defendants claim could offset that competitive harm.

First, I would like you to talk about entry and expansion.

A. Sure.

Q. And focusing for the moment on entry, what factors did you consider to determine whether there was any likely entry that might offset the transaction's competitive effects?

A. Again, a combination of theory and facts on the ground. The theory of entry tells us to focus on entry barriers. Are there obstacles to coming into the market? And for primary care physicians coming into a new market, the entry barriers are considerable. It's not as simple as hanging up a shingle and expecting patients to come to see you.

You might come in and try lowering your price. But, as we discussed, patients who are in-network aren't very sensitive to prices. You're going to have to establish a reputation so you can get recommendations. You can't get recommendations from other patients if you don't have any patients to begin with.

You're going to -- to be an effective physician, you're going to have get integrated into a referral network. You are going to have to, of course, lease an office and hire staff and get equipment.

All of these are expensive, which I think helps

explain why, if you look at entry into Nampa over the last several years, all of the physicians who have come into the market have come into established group practices. You don't see de novo entry.

And, in fact, as a result of the entry we have seen, the market shares pretty much haven't changed very much over time. You see the same balance of dominant Saltzer, St. Luke's before that, Mercy before they acquired them, Saint Al's. You know, you see pretty good stability in terms of market shares.

Q. So what about expansion of existing players? You talked about some recruitment, for example. Did you consider expansion as a means by which the competitive effects could be restrained in this case?

A. So while expansion by existing players doesn't necessarily entail the same number of barriers in terms of success, it still has a number of barriers. The existing players are going to have to convince enrollees to switch. And, again, by reducing prices is not going to be an effective strategy. Price reductions within network just don't drive demand very much.

Existing players -- well, we already have one, for example, Saint Al's, which does, as far as I can tell from what I've seen, have some capacity. They have had a difficult time attracting patients because it's hard to get

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patients to leave their preferred providers. Patients establish relationships with their doctors, especially in primary care, and they don't want to leave them.

And then, just as a final point, even if the capacity was there -- let's remember what we learned from the diversion analysis. If you do tell your enrollees, "Hey, we're not going to let you see Nampa -- we're not going to have St. Luke's or Saltzer in the best tier. If you want to get low cost-sharing, you've got to go to somebody else," you're going to be telling a very high percentage of your enrollees that not only can they not go to their most preferred doctor, they can't go to their second-most preferred doctor.

And that's going to make it very hard to convince employers to accept a network in which all of their employees who want to stay in Nampa are told, "Go to Saint Al's."

Q. So this goes back to your earlier discussion about the outside option dynamic?

A. Yes. I mean, it's the same point I have been trying to hammer home that this merger does one thing: It doesn't change the bargaining power of insurers. It doesn't change the ability to -- for insurers to threaten to detiering. It doesn't change the potential for entry. It doesn't change the potential for capacity.

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It changes the strength of the outside option for an insurer that chooses not to go with Nampa and/or St. Luke's. And it makes that outside option less attractive, increases the bargaining leverage for St. Luke's and Saltzer, which will lead to more revenues flowing to St. Luke's and Saltzer.

Q. Thank you, Professor Dranove.

Let's turn to the primary defense offered by defendants, and that would be efficiencies. I guess, just to set the stage, Professor Dranove, can you explain what the theory in evidence on vertical integration is?

A. So, by vertical integration, I assume you mean the acquisition of physician practices by hospitals. And vertical integration in this case is an example of the more general phenomenon where two firms at different stages of the production process -- so, coming back to our auto example, this could be General Motors acquiring a parts assembly -- parts manufacturing or parts assembly plant. There is theory as to whether or not vertical integration is likely to lead to efficiencies.

Vertical integration, sometimes described somewhat inaccurately in healthcare as clinical integration; sometimes described more accurately as financial integration -- maybe we will have time to talk about those.

Vertical integration sometimes is invoked as if

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just saying the terms means you have accomplished something positive. But, in fact, both theory and economic evidence say that there are tradeoffs involved when you vertically integrate.

So that vertical integration might sometimes lead to efficiencies that could get passed on to consumers, might sometimes fail to lead to efficiencies, might sometimes lead to higher costs and higher prices that also get passed on to consumers but in a harmful way.

So the theory on vertical integration is decidedly mixed, and the evidence on vertical integration in healthcare is also decidedly mixed in a way I like to describe as "unambiguously ambiguous."

You can line up a set of papers that show that vertical integration has led to lower costs or lower prices, but you could line up an equally long set of papers that fail to find that result.

Some of the papers have better methods than others, but anybody who would look at this literature and say, "I know what the outcome of vertical integration and healthcare is going to be," I think is wishful thinking.

Q. Has St. Luke's engaged in this kind of vertical integration that you're describing in recent years?

A. Their acquisitions of many primary care physicians practices is a classic example of vertical integration in

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healthcare.

Q. And have St. Luke's experts suggested that those acquisitions lowered the cost of healthcare services?

A. Professor Enthoven quite explicitly, and Dr. Argue in support of Professor Enthoven, suggest that these past acquisitions of primary care physicians services have reduced healthcare spending for patients who are being managed by the physicians who were acquired.

Q. And in light of that, did you perform any analysis to test that claim by St. Luke's experts?

A. Yes, I did. I performed an analysis that looked at the actual spending on patients who were managed by physicians acquired by St. Luke's, and I looked at how that spending changed before and after the acquisition.

But I recognized that over the same time that the acquisition is taking place, healthcare spending might be increasing for all patients, not just for the acquired patients. Well, perhaps it's decreasing for the patients of acquired physicians and increasing for other patients, in which case it would be truly a dramatic savings.

So, in order to figure out the actual effect of these acquisitions on the spending of the patients who are being managed by these physicians, I performed what's known as a difference-in-difference analysis. And the best way to see that is with kind of a hand version of bar charts.

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So imagine that we can measure the percentage change in health spending for patients whose doctors have been acquired. And say we come up with a 10 percent change.

Now, 10 percent sounds like a big increase. But maybe over the same period of time, costs for patients whose doctors were not acquired went up by 15 percent. Well, I think, intuitively, we would say: The acquired docs are doing 5 percent better -- 15 minus 10.

And that's what difference in difference is. It takes the 15 percent change or difference in price for the control group, the doctors who weren't acquired, and compares it to the 10 percent change or difference in price or spending for the experimental or treatment group, the doctors whose practices were acquired.

So that's what I'm comparing in my analysis.

Q. Based on your analysis, what did you find?

A. The analysis involved a number of different looks at the data. For example, considering different ways of identifying patients whose doctors -- patients whose care was being managed by a doctor.

So if you were a patient and you saw five different primary care physicians during the course of two years, I don't think that fit Dr. Enthoven's version of what being managed was. Although, again, I tried different versions of this because Professor Enthoven didn't

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articulate a particular research strategy, and so I tried a number of different versions.

And regardless of which statistical approach I took, I could find no evidence that the expenditures for medical care for patients whose doctors were acquired by St. Luke's had fallen relative to expenditures for medical care whose doctors had not been acquired by St. Luke's.

So, at least to date, there is no systematic evidence that vertical integration has led to lower spending for the patients of St. Luke's primary care physicians.

Q. I just want to make sure I understand your testimony, Dr. Dranove.

Did you attempt to measure St. Luke's market power in these experiments?

A. No, I did not. In fact, it would not surprise me if some of the physicians that they acquired were physicians in markets that were more competitive than the Nampa market.

This was strictly a test of the claim that if St. Luke's acquires primary care physicians, that will translate in a reduction in medical spending for their patients.

I'm not saying it won't happen in the future. The theory on this, again, is ambiguous. What I'm saying is the evidence to date suggests that it has not happened yet.

Q. And based on your findings, what does that suggest

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to you about the likely efficiencies from the Saltzer acquisition?

A. So when I talk about the theory and evidence being mixed, that means that, in some cases, some people may unlock the mystery. They may figure out how to make vertical integration work.

But theory and evidence suggest that there is -- it's not predictable. It's not systematic. You can't tell beforehand. Everybody says the right things about vertical integration. Everybody says we will be clinically integrated, which has something to do with changing the way medical care is delivered. But when you look at what actually happens, the evidence is mixed.

But some people will unlock the key. And thus far, St. Luke's, in the time frame that we have looked at, has not yet unlocked that key, unlocked that mystery.

Q. Well, let's assume counterfactually, if you will for the moment, that you found that healthcare costs went down following these various PCP acquisitions. Would that be the end of your analysis of efficiencies?

A. No. I think one of the additional points that's been raised about this -- this goal of clinical integration, this idea of changing the way healthcare delivery is done is that it's not necessarily required that you acquire physicians in order to make it happen.

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There can be relationships between independent hospitals and physicians that still result in clinical integration and reductions in spending.

And so even if St. Luke's has shown that they have reduced spending, I would be concerned that they could achieve this without increasing market power. And there is a lot of theory and evidence to suggest that independent providers also have been able in some circumstances to reduce spending.

Q. Now, I want to make sure we have some nomenclature clarified. On the slide, you have the phrase "merger specific." Can you just explain what that means to the court?

A. Sure. So the efficiency is merger specific if the only way to achieve it is through a merger. If you can achieve the same efficiency without the merger, then you get the best of both worlds: You get the efficiency and you sustain competition.

Q. You have used the phrase "vertical integration." You have also used the phrase "financial integration." How are those the same or different?

A. So I tend to think of vertical integration as more like financial integration where two organizations combine under a single ownership structure. And that's separate from clinical integration, where there is a reconfiguring of

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how medical care is delivered, which could be done by independent providers. They don't have to be in the same organization.

Q. So now that we have gotten some of the nomenclature clarified, what does it mean to your analysis if a claimed efficiency is not merger specific?

A. If it's not merger specific, that means that it's not a justification for the merger. You could achieve the same good without merging, without the harm of the increase in market power.

Q. Now, you mentioned that clinical integration does not necessarily require financial integration. Did I understand your testimony?

A. That's correct.

Q. Are there any examples you can think of where clinical integration has been achieved without financial integration?

A. Very close to home is a terrific example of a large healthcare system in the Chicago metropolitan area, the Advocate system. Advocate owns about 10 or 12 hospitals in the Chicago area.

They also do employ a large number of physicians, but they also engage a large number of independent physicians. In fact, they have probably about the same number of independent physicians as they have employed

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physicians.

And the independent physicians are very active in the development of clinical guidelines and treatment protocols and other ways of changing the way healthcare is delivered, showing that a mixed model is certainly very viable where some doctors are employed and some doctors remain independent.

The independent doctors negotiate their own rates separately from the Advocate doctors and, yet, remain fully committed to clinical integration.

Q. A little earlier in your testimony you talked a little bit about the effect of leverage on risk-based contracting. I'm going to flip that a little bit and ask: What about risk-based contracting as an efficiency? Does that require employment of physicians in your view?

A. Physicians don't have to be employed. We have seen, through health maintenance organizations and other types of organizations, contracts written directly with providers by insurers.

And with a large physician group like Saltzer, you could even imagine an insurer writing a direct risk-based contract directly with Saltzer. Things like that have been done all over the country in the past.

Q. Now, you're familiar with the Saltzer PSA that governs the relationship with St. Luke's?

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A. Yes, I am.

Q. And focusing specifically on that, how do the terms of that contract inform your analysis of risk-based contracting as an efficiency?

A. If you'll remember before the break, quite a bit before the break, we were talking about the fact that risk-based contracting is kind of a catchall term. And an example of a risk-based contract would be like a per-member/per-month contract. These types of contracts often fix the payments to the providers as a way to incentivize them to hold down spending. And a lot of people believe that these are -- are efficient because they will lead to lower healthcare spending.

Many people are concerned, however, that in the absence of competitive market check, they could lead to too low market spending. This was one of the factors behind the HMO backlash of the 1990s.

REDACTED

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REDACTED

Q. Given everything we have discussed today, Dr. Dranove, can you summarize your conclusions for the court?

A. Sure. I think in order to understand the impact of this merger, we have to understand that if you want to see low prices in the private healthcare marketplace, you have to see effective negotiations between insurers and providers, that patients do not impose pricing discipline on the market.

This merger is going to affect the negotiations between insurers who are covering enrollees in the Treasure Valley and the two largest providers of primary care for commercially insured enrollees in Nampa -- Saltzer and St. Luke's. I believe it's going to tilt their marketing leverage towards Saltzer and St. Luke's, leading to higher payments to the providers.

And with ambiguous theory about the efficiency effects and no evidence from the facts that I have examined about efficiencies, I just don't see any offsetting argument

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to justify this anticompetitive merger.

MR. HERRICK: Thank you.

Your Honor, I have no further questions at this time.

THE COURT: Mr. Stein.

MR. STEIN: Your Honor, I believe we can open the courtroom.

THE COURT: We can?

MR. STEIN: Yes.

THE COURT: All right.

****** COURTROOM OPEN TO THE PUBLIC ******

MR. STEIN: Your Honor, we also have some binders for Dr. Dranove if we can move the other binders.

THE COURT: Yes.

CROSS-EXAMINATION

BY MR. STEIN:

Q. Good morning, Dr. Dranove.

A. Good morning.

Q. You're an economist, not a medical doctor; is that right?

A. That's correct.

Q. Let me make sure I understand the basic point of selective contracting. In the context of this case, would it be fair to say that really what you're saying is what's good for Blue Cross of Idaho is good for consumers?

A. I haven't said that.

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Q. I know you haven't said it that way, but that's basically what you're saying; right? If something is bad for Blue Cross of Idaho's negotiating position, then that's going to translate into harm to consumers?

A. I think what's good for purchasers acting as representatives for employers is good for employers and their employees. Blue Cross is one of those purchasers.

Q. Right. So what's good for Blue Cross of Idaho is good for consumers?

A. Well, you make it sound like it's only good for Blue Cross of Idaho. If it was -- if it was not also good for other purchasers, I might not -- I don't think I would agree with that statement.

Q. By you do agree with it?

A. No. I don't agree with the statement because your statement is: Is it good for Blue Cross of Idaho? And I need to know in context: Is it also good for other purchasers?

Q. You have been retained as an expert witness in antitrust-related matters several other times; is that right?

A. Yes, I have.

Q. In addition to being retained by the Federal Trade Commission in this case, you have been retained as an expert witness two other times by the Federal Trade Commission?

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A. I believe that's true, yes.

Q. You have been also been retained to do work for an organization called America's Health Insurance Plans; is that right?

A. Yes. I prepared a short comment on a research study on behalf of America's Health Insurance Plan.

Q. That's the trade association for Blue Cross of Idaho and other health insurance plans around the country?

A. I don't know if Blue Cross of Idaho is a member, but it is a trade association for insurers.

Q. In fact, you have previously been paid as an expert witness in an antitrust case by Blue Cross of Idaho; right?

A. Actually, I'm not aware of what you're alluding to. Prior to this case? I'm -- you'll have to refresh my memory.

Q. You don't remember whether you have testified as an expert witness for Blue Cross of Idaho in an antitrust case in this court?

A. I have been deposed, but I don't recall testifying on behalf of Blue Cross of Idaho. Again, you'll have to refresh my memory.

Q. Have you ever done any expert witness work for Blue Cross of Idaho?

A. I don't recall ever having done so.

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Q. Can we pull up Exhibit 5007.

I'm showing you here a document called "Petition for Costs and Attorneys' Fees" filed in a case entitled Government Employees Medical Plan, aka GEM Plan, versus Regence Blue Shield and Blue Cross of Idaho Health Services.

This was a case that was in this very courtroom, Dr. Dranove. Does this bring back any memories?

A. No, it doesn't. No, it does not.

Q. So let's turn to page 11. This is a document titled "Affidavit of Geoffrey M. Wardle" filed in support of Blue Cross's petition for costs and fees. Do you see that?

A. Yes, I do.

Q. Dr. Dranove, I see you squinting at the screen. This document is in the binder, if it would be easier for you to review it that way.

A. Can you tell me where I should look?

Q. It would be a tab that says "5007."

A. Okay. Okay.

Q. And in this document that's titled "Affidavit of Geoffrey Wardle," if we can turn two pages in.

A. Okay.

Q. Let's just blow up paragraph 10.

That's on the screen, Dr. Dranove. It might be easier to see.

A. Okay. Thank you.

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Q. It says, "The costs set forth in Exhibit G are the billing invoices paid by Blue Cross associated with retaining an expert and economic consultants to evaluate the plaintiffs' claims and to respond to the report produced by the plaintiffs' experts purporting to establish the existence of antitrust violations by Blue Cross. The amounts set forth in Exhibit G represent actual amounts incurred by Blue Cross for services in defending this matter."

Do you see that?

A. Yes, I do.

Q. So let's go to Exhibit G. Let's turn to the next page. Could we call that out.

A. Yes, I do.

Q. Do you see the first name listed there?

A. Yes, I do.

Q. That's your name; right?

A. Yes, it is.

Q. Can we go to the second page. And let's call up the bottom part of the page regarding who payment should be sent to.

Is that you, Dr. Dranove?

A. Yes, it is.

Q. Does this refresh your recollection that you have been paid as an expert in a case involving Blue Cross of

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Idaho?

A. Honestly, no. I don't recall the work on this. I do see that it amounted to just a handful of hours, so --

Q. You admit, though, that this is you?

A. Yeah, obviously.

Q. That just -- the fact that you did previous expert witness work for Blue Cross of Idaho in an antitrust case, that just escaped your memory?

A. I have no recollection of it.

Q. Now, Dr. Dranove, you're not offering any opinion concerning the competitive effect of the Saltzer transaction on the market for pediatric primary care services; correct?

A. That's correct.

Q. And you're not offering any opinion concerning the competitive effects of the Saltzer transaction on the market for general acute inpatient hospital services; correct?

A. That's correct.

Q. And you're not offering any opinion concerning the competitive effects of the Saltzer transaction on any markets for outpatient hospital services?

A. That's correct.

Q. And you're not opining that Saltzer had market power prior to the transaction with St. Luke's; correct?

A. I have not done a formal analysis of its market power beforehand.

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Q. So you're not offering an opinion that Saltzer had market power prior to the transaction with St. Luke's; correct?

A. Beyond what I stated that it had a large -- a dominant market share and had been described by dominant.

Q. Mr. Dranove -- Dr. Dranove -- excuse me -- I am going to ask you a very specific question, and I would like a very specific answer.

A. Okay.

Q. You are not opining that Saltzer had market power prior to the transaction with St. Luke's; correct?

A. I don't -- no.

Q. My statement is correct?

A. I'm sorry. Let's see. I stated that it -- that Nampa was a well-defined market and identified that Saltzer had over 60 percent market share. I think that evidence stands for itself as evidence that it had market power. By definition, if you have such a large market share in a well-defined market, you almost certainly have market power.

So I haven't used the words explicitly, but I have pretty much stated that through the evidence that I cited.

MR. STEIN: Let's play clip DR31. For the record, this is Dr. Dranove's deposition at page 99, 23 to 100, line 5.

(Video clip played as follows:)

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Q. "So, just to be clear, because we have stumbled across this term consistent before -- or I have, at least -- are you offering an opinion that prior to the Saltzer transaction with St. Luke's, Saltzer had market power in the market for adult primary care services in Nampa?"

A. "I have not offered that opinion in my reports, and I was not asked to assess that."

(Video clip concluded.)

BY MR. STEIN:

Q. You were asked that question and you gave that answer --

A. Yes.

Q. -- Dr. Dranove, didn't you?

A. Yes.

Q. And now you're saying you do have such an opinion?

A. I have not offered that opinion explicitly.

THE COURT: Counsel, similar to my last comment, the witness simply indicated that he had not been retained to offer that opinion. And then you asked him a question here and asked him to essentially form an opinion or whether he had. I think those are two different questions. So, in fairness, in using impeachment, I think they have to be the same question and a different response.

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But let's go ahead and proceed.
MR. STEIN: Your Honor, I believe I didn't ask him whether he was retained to do so. I asked whether he had, in fact, offered an opinion.
THE COURT: Well, I heard the testimony. Let's go ahead and proceed.
BY MR. STEIN:
Q. You have done no independent analysis of the quality of care provided by St. Luke's as compared to the quality of care provided by its competitors; right?
A. That's correct.
Q. And you have done no independent analysis of referral patterns by physicians affiliated with St. Luke's?
A. That's correct.
Q. You have done no independent analysis of the effect of the Saltzer transaction on either Saint Alphonsus or Treasure Valley Hospital?
A. Correct.
Q. And you're not offering an opinion that the Saltzer -- strike that.
You're not offering an opinion that the Saltzer transaction will cause anticompetitive harm to Saint Alphonsus or Treasure Valley Hospital?
A. Correct.
Q. And despite there having been, as you said,

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20-some-odd prior acquisitions of primary care practices by St. Luke's, you did not study the effects on competition of any prior acquisitions by St. Luke's; correct?
A. That's correct.
Q. And you have done no economic analysis of the competitive effects of any acquisition by St. Luke's other than the Saltzer transaction; is that right?
A. Correct.
Q. So, for example, you have done no analysis to determine whether any prior physician practice acquisition by St. Luke's resulted in an increase in prices above competitive levels?
A. I'm sorry. Could you repeat the question?
Q. You have done no analysis to determine whether any prior St. Luke's acquisition of a physician practice resulted in an increase in price that was above competitive levels?
A. Correct.
Q. And you're not opining that St. Luke's has market power in the Magic Valley; correct?
A. Correct. The same proviso as before. I provided evidence but haven't made an explicit statement to that effect.
Q. And you talked in your direct testimony about Twin Falls and Jerome. Which of those is larger?

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A. I believe Twin Falls.
Q. And if we're drawing an analogy between Twin Falls and Jerome and the Treasure Valley, which city would be Twin Falls?
A. I actually don't know the relative size of Twin Falls. My understanding is it's more comparable in size to Nampa than to Boise, but I don't recall. So I'm not prepared to say which one I think would be Twin Falls.
Q. Well, I'm just asking if the judge -- if the judge is trying to draw an analysis between what happened in Twin Falls and what you're saying is going to happen in the Treasure Valley, what are the two cities that the judge should be thinking about in the Treasure Valley?
A. I don't know. All I can say is that I know Twin Falls, I believe, is the largest city in the Magic Valley. But, again, I think relative size is just one thing. I think the absolute size would also be an issue. And so I'm not ready to tell you which one I think is the most appropriate point of comparison.
Q. And the point of your Magic Valley testimony, I think, or part of it was to say in that situation, patients who lived in the large city of Twin Falls didn't want to travel to the smaller community of Jerome to get care; is that right?
A. That a network that did not include physicians in

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Twin Falls but did include physicians in a neighboring but smaller community was not an attractive option.
Q. And you testified that not having -- not having physicians in Twin Falls was a hole in the network for the payor you were talking about?
A. Yes.
Q. It didn't stop that payor from signing up the largest -- its largest customer in the state, did it?
A. I don't recall.
Q. You have not been asked to offer any opinions about the appropriate remedy in this case in the event that the Saltzer transaction is deemed anticompetitive?
A. That's correct.
Q. And you have done no independent analysis of whether an unwound Saltzer would be viable in the event that the transaction is unwound; correct?
A. That's correct.
Q. Now, the ability of a firm to raise prices, standing alone, is not evidence of market power; correct?
A. I'm sorry. I don't understand the question when you say "standing alone, is not evidence of" --
Q. One cannot conclude from the observation that a firm has raised prices that it has market power?
A. Oh, I'm sorry. Okay. That's correct.
Q. And, likewise, one cannot -- one cannot conclude

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from the fact that a merger has led the -- that -- strike that.

One cannot conclude from the fact that after two firms merged, the merged entity raises prices, that the merger has resulted in market power; correct?

A. Based on that information alone, that's correct.

Q. And in order to determine whether an increase in prices reflects the exercise of market power, an economist needs to determine whether the increase in price is above the price that would be sustained in a competitive market; correct?

A. Yes.

Q. And economists -- when economists talk about a price increase above the price that would be sustained in a competitive market, that's referred to as supercompetitive pricing?

A. Correct.

Q. In your direct testimony, you referred to talking about what one sees when one reviews contracts between payors and providers. Do you recall that?

A. Yes.

Q. You didn't actually review any of the contracts between any of the parties and payors in this case; correct?

A. No, I did not.

Q. And you have done no independent analysis of how

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St. Luke's prices compare to its competitors' prices; correct?

A. I have not offered an opinion in my reports. I do recall having done some preliminary analysis.

Q. But that's not included in your report?

A. It's not included in my report.

Q. And you're not opining that St. Luke's is charging supercompetitive prices; correct?

A. I have not done an independent analysis of that.

Q. You referred to the fact that one of the things that gives -- that gives St. Luke's some leverage is that it has unique services.

A. Yes.

Q. And Saint Alphonsus also has some unique services --

A. That's correct.

Q. -- right?

So Saint Alphonsus also has some degree of leverage in its negotiations with payors?

A. Yes.

Q. Professor Dranove -- I'm sorry if I refer to you as "Professor Dranove" from time to time. Is that --

A. That's fine.

Q. You won't be offended?

A. Sure.

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Q. You are a professor?

A. Yes.

Q. This is a slide in which you were discussing this two-stage model of competition in selective contracting; is that right?

A. Mm-hmm, yes.

Q. And your two-stage model of competition assumes that there is very little, if any, price competition between providers who were in network in that Stage 2; is that right?

A. I don't think that's just an assumption. I think that's a conclusion based on economic theory and prior empirical research.

Q. But health plans and employers can design plans that make price an important consideration for patient choice among in-network providers; correct?

A. I mean, they can write contracts with different cost-sharing provisions. Whether the providers are still considered to be in network or not might depend on the types of provisions that they put in place. So there are things that employers -- that insurers can do to change the contract provisions.

Q. And to create price differences for providers who are in network; right?

A. That would require, for example, creating separate

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tiers by having different cost-sharing arrangements than you have -- within a given network tier, you would still have the same issue of the cost sharing being comparable, but across tiers, you would have different levels of cost sharing.

Q. Right. And we know there are different examples of plans in this market in which there are price differentials among in-network providers; right?

A. Again, thinking in terms of tiers, I am aware of the Micron example of tiering. I am not aware of other examples of tiering in this market.

Q. How about Boise schools?

A. They may have tiers. I just didn't recall.

Q. Idaho Power, they had a plan with tiers?

A. I believe both of those may have had plans with tiers but then abandoned them. So, currently, I'm not sure what other examples there are.

Q. Does Woodgrain have a plan that provides financial incentives for the use of one in-network provider over another?

A. I am not familiar with Woodgrain.

Q. How about Paul's Market?

A. I am familiar with Paul's Market, and I understand that they have excluded St. Luke's from their most preferred network, but I don't know if they have tiers.

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Q. How about Thomas Cuisine, do they have incentives for the use of one provider over another?
A. I am not familiar with Thomas Cuisine.
Q. And you talked about narrow networks a little bit. A health plan could offer multiple options; right? It could offer a broad plan that includes all the providers at a higher cost, and alongside that, it could offer a narrower network that would presumably cost less; correct?
A. Yes.
Q. And those patients who valued broader physician choice could choose a PPO plan, and those who maybe valued a lower price and didn't value choice as much could go to a narrow network plan; right?
A. Not necessarily. If, say, St. Luke's and Saltzer chose not to participate in the narrow plan, then that would mean that the 80 percent of the people who live in Nampa who choose those as their preferred providers and want to see them would not choose the narrow plan. They wouldn't be able -- they would simply not view the narrow plan as an option.
Q. Well, they would have to go to another plan that did include Saltzer and St. Luke's if that was their primary driving consideration; right?
A. Yes. Eighty percent of these folks would have to basically want to pay a -- be willing to pay a substantially

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higher percentage for their medical care in order to -- and in exchange, they wouldn't get to go to St. Luke's or Saltzer, yes.
Q. But you said that in Idaho and, generally, hospitals and payors will typically sit down and negotiate what I think you referred to as the number in the bottom right-hand corner of the spreadsheet?
A. Yes.
Q. And then that -- that figure will be allocated in different ways across the whole range of services; right?
A. Yes.
Q. So that -- let's say that the hospital negotiates an increase of 5 percent. That increase would then be allocated among, what, thousands of different CPT codes?
A. I think it depends on the result of the contract negotiation. Potentially, yes.
Q. Some may go -- some CPT codes may go higher, some may go lower; is that right?
A. That's correct.
Q. So you couldn't, let's say, reach any conclusions about whether one hospital is more or less expensive than another by just looking at some subset of a couple of dozen CPT codes; right?
A. I think it would depend on -- on the representativeness of those CPT codes, what percentage of

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total billings they account for.
If those CPT codes represented a cross-section of services and consistently we saw higher prices for those CPT codes, and if those CPT codes weren't cherry-picked to show that, then, in that case, I think the statistical evidence would be clear that, on average, we would expect the prices were higher.
Q. Now, hospitals don't charge patients different prices depending on where the patient lives; right?
A. Correct.
Q. So hospitals in Boise don't charge patients in Boise a different price than they charge a patient who comes from Eagle or Meridian; right?
A. Correct.
Q. So, as a practical matter, if St. Luke's were able to obtain a supercompetitive price increase in a negotiation with a payor, that's going to affect patients not just in Nampa but in other communities?
A. If they impose an across-the-board price increase, yes.
Q. By "across-the-board," you mean to distinguish that from, say, a price increase that would be just focused on Nampa residents?
A. Yes, yes.
Q. And if St. Luke's were to impose a

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supercompetitive price increase across the board, that means, by definition, it would be extending it into communities in which St. Luke's did not have market power for physician services; correct?
A. No. In fact, I would interpret that evidence completely opposite, that in the absence of some evidence that there was some sudden quality increase that had not been there beforehand, if they imposed that price increase across the board and did not lose every one of their patients in the communities in which they imposed it, that would be prima facie evidence that they did have market power or at least faced a downward sloping demand curve in those communities, which is exactly what you would expect.
Q. That's interesting. So let's talk about what you see happening as a result of this transaction.
So you have testified that the transaction would give the combined entity market power. Tell me how you think that market power will be exercised. Where will we see it show up?
A. In the bottom right-hand cell. And beyond that, it's left up to the negotiators.
Q. Well, but you just told me that at least there is one way St. Luke's couldn't exercise it, which would be to extend it into markets where there is not market power.
A. That's exactly the opposite of what I said. I

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said that if they do that, unless they lose a hundred percent of their patients, that would be prima facie evidence that they face downward sloping demand.

And, in fact, I -- in market after market that I have studied, and I think it's just plain-old common sense, physicians who -- or hospitals or specialists, if they raise their price by 5 or 10 percent, they're not going to lose a hundred percent of their customers.

In fact, we learned our history before selective contracting that pricing discipline doesn't take place from the point of view of insured patients choosing with their feet based on slight changes in prices.

Q. How many customers will they lose?

A. Probably not too many, based on the evidence we have seen historically that pricing doesn't affect patient choice of provider.

Q. And how many employers might decide, if St. Luke's raises its prices and that causes premiums to go up, maybe they won't offer coverage anymore?

A. Not as many as would have made that decision prior to the acquisition of Saltzer. Because with the -- prior to the acquisition of Saltzer, they had a good alternative; but after the acquisition of Saltzer, they don't.

Q. Did you say not as many?

A. Not as many.

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Q. So you think that a result of the -- you think the Saltzer-St. Luke's transaction makes it less likely that employers will drop insurance coverage?

A. That's not the -- that makes it less likely that they will walk away from a network that includes Saltzer and St. Luke's.

Q. Well, but if prices go up and if St. Luke's and Saltzer increase prices -- and according to that chart you had, that goes right down to the bottom line of employers -- if that means health insurance gets more expensive for employers, some of them might decide to limit or just not offer coverage anymore; right?

A. I think that effect would be very, very small and pale in comparison to the number of employers who would be agreeing to accept higher rates because they want to keep Saltzer and St. Luke's in their network.

Q. Sure. But you really -- you haven't done any quantitative analysis of that in your report, have you?

A. I think I have in my original report or my follow-up report --

Q. You've got it right there. Why don't you point me to the page where you have done that quantitative analysis.

A. Frankly, I don't remember. It's a very, very small passage. And I don't have it as a major heading, but I just make the observation that price -- that despite

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rising health insurance premiums over the years, there has been very little dropping of health insurance coverage.

Q. Can you give me a cite for that?

A. I can't find the page or tell you which report it's in, but that's essentially the argument that I made.

Q. Now, when you define the market -- strike that.

The market in which you analyzed competitive effects was the market involving commercially insured patients; is that right?

A. That's correct.

Q. And does that include patients who are covered by Medicare Advantage plans?

A. I have not done an independent assessment of Medicare Advantage, but many of the same principles might apply.

Q. When you define "commercial," you excluded from that Medicare Advantage; correct?

A. Correct. One can.

Q. The market for commercial insurance in Idaho is fairly concentrated, isn't it?

A. Yes, it is.

Q. Blue Cross of Idaho is the largest commercial insurer in the state?

A. Yes, it is.

Q. Does Blue Cross of Idaho have market power in the

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market for the purchase of services from healthcare providers?

A. I haven't done an analysis of that, and it's hard to say.

Q. You didn't think it was important in offering opinions about bargaining leverage between St. Luke's and Blue Cross to determine whether the largest payor in the state has market power in the market for purchasing services?

A. My concern in this case was the effect of the merger on changes in bargaining leverage.

Q. So you didn't think it was important to answer that question?

A. Blue Cross's bargaining leverage, to the extent it has it, is a constant and, therefore, not relevant to assessing the effect of the merger on the change in leverage.

Q. Bargaining leverage is a zero-sum proposition; right?

A. Yes, it is.

Q. So what -- and what that means is, if two parties sit down to a negotiation, if one party's leverage goes up, the other party's leverage, by definition, goes down?

A. That's right.

Q. And under your theory, any merger of competitors,

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no matter how small, increases the merged entity's leverage?
A. Anywhere from a de minimis amount to potentially a substantial amount.
Q. Right. But even if the 999th and 1,000th largest competitors in a market merged, by definition, that would increase the merged entity's bargaining leverage?
A. That's true in economic theory in any markets whatsoever where you have sellers of differentiated goods that have any degree of substitution whatsoever. It's not unique to my testimony.
Q. And any merger of competitors will therefore result in an increase in bargaining leverage regardless of whether the merger results in market power?
A. Any -- there is an increase in bargaining leverage, again, anywhere from de minimus amount to a substantial amount.
Q. Right. But the increase in bargaining leverage occurs whether or not the merger creates market power?
A. Yes.
Q. So the fact that a merger increases the combined entity's bargaining leverage is not a sufficient basis on which to find that it violates the antitrust laws?
A. Without examining the extent of the increase in leverage, that's correct.
Q. And you are not testifying that there will

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necessarily be any increase in prices for physician services as a result of the Saltzer transaction; correct?
A. Correct.
Q. And you haven't provided an objective benchmark for the court to use to determine when an increase in bargaining leverage reaches the level at which it confers market power; right?
A. I have used the merger guidelines as a way of identifying how increases in bargaining leverage resulting from an increase in market shares might be anticompetitive.
Q. But you haven't provided a benchmark from which the judge can conclude that a particular increase in bargaining leverage creates market power?
A. Again, I have used the merger guidelines as my benchmark.
Q. So a -- and explain how that works. So any merger that -- that results in a -- well, I'll tell you what. Why don't you explain the explanation between --
A. Sure. If the bargaining parties are in a concentrated market, there aren't very many alternatives for sellers, and their merger increases their shares. That will generate a substantial increase in market concentration, which translates into a substantial increase in bargaining leverage.
Q. So if the concentration levels reach the

1400

thresholds in the merger guidelines, then you would conclude that whatever the increase in bargaining leverage would be anticompetitive?
A. No. Again, you know, the merger guidelines are guidelines. Here, the concentration levels are substantially higher, and there is other evidence, including testimonial evidence, to suggest that this might be anticompetitive.
Q. Now, you've talked some in your direct testimony about Blue Cross's BATNA, or best alternative to a negotiated agreement?
A. Yes.
Q. So let's focus on the other party to those negotiations. What's St. Luke's best alternative to a negotiated agreement with Blue Cross?
A. Well, if St. Luke's did not reach an agreement with Blue Cross, they would probably do what many providers have done around the country when they fail to reach an agreement.
During the open enrollment period that most employees have with their health plans, they see some advertisements on television saying St. Luke's is not -- well, they probably wouldn't mention -- say Blue Cross was the plan they didn't have an agreement with. They would say St. Luke's is in the Regence network. St. Luke's is in the

1401

PacifiCare network. Please make sure that you get these -- that you sign up for one of the networks that has St. Luke's.
Q. Well, isn't St. Luke's best alternative to a negotiated agreement going out of network?
A. St. -- well, that is part -- their best alternative, what they would do as a business entity to try to make themselves whole, is to get enrollees to switch to another plan that they're in-network.
Q. Maybe they would succeed, maybe they wouldn't. But when you say switch employee -- switch to another plan, that would involve ultimately going out of network for Blue Cross?
A. No, because if enrollees switched to those other plans, those enrollees remain in network.
Q. Can St. Luke's afford to go out of network for Blue Cross?
A. I have not studied how effective the strategy would be. I have seen the strategy used in other markets very successfully.
Q. What happens to St. Luke's volumes if it goes out of network for Blue Cross?
A. If it goes out of network for Blue Cross, I suspect its volumes will fall.
Q. Have we seen any examples in this market of plans

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where St. Luke's has gone from being an in-network provider --
I'm sorry, Tammy.
Have we seen any examples in this market of plans where St. Luke's has gone from being an in-network provider to an out-of-network provider?
A. I think you're referring to Micron.
Q. And what happened to St. Luke's market share when it went out of network?
A. They lost -- they lost substantial volume.
Q. So if we can go back to the slides that you were going through with plaintiffs' counsel. Go to slide 16.
There is a perhaps provocative title here: "Increased provider leverage harms consumers."
A. Yes.
Q. Is that true as a blanket statement?
A. Absent any efficiency gains from the deal, this taken in isolation, I believe is correct, yes.
Q. Well, you just said earlier that any merger of providers increases provider leverage; right?
A. Anywhere from a de minimus amount to a substantial amount.
Q. Right. So then what you're saying is that any merger of providers harms consumers?
A. Anywhere from a de minimus amount to a substantial amount, yes.

1403

Q. Now, the slide here indicates that a provider with increased leverage can obtain higher negotiated rates for services; right?
A. Mm-hmm; correct.
Q. But higher negotiated rates for services are not of any concern under the antitrust laws unless the higher negotiated rates are supercompetitive; right?
A. I'm not aware of what the antitrust laws say about how to interpret that. I am simply stating here those higher rates will harm consumers.
Q. Whether or not they are supercompetitive?
A. Again, that's a legal distinction that I have never really -- at least in the context of this case, I haven't thought deeply about. I'm not prepared to opine.
Q. So your conclusions about the anticompetitive effects of this transaction are just based -- are based with respect to pricing just on the conclusion that the transaction will result in higher prices?
A. That it will result in a bigger right-hand corner, a substantial increase in payments to the merging providers, yes.
Q. You referred to a Dr. Elzinga in your testimony. Do you recall that?
A. Yes, I did.

1404

Q. And Dr. Elzinga is associated with what is known as the economist Elzinga-Hogarty test?
A. Yes.
Q. Dr. Argue did not conduct an Elzinga-Hogarty test; is that right?
A. He carried out the most important first step in that test, which is an analysis of inflows and outflows, but he did not carry out a full-blown Elzinga-Hogarty market definition.
Q. Even Professor Elzinga has noted that there may be situations where only a few patients travel at current prices but where substantial -- a substantially higher number of patients would travel at a change in prices; right?
A. Yes.
Q. And just to talk about this travel point for a minute. If I understand what you're saying in a nutshell, it's that we can't learn a lot about what -- where patients might go for care if prices increased by looking at where patients currently go for care; right?
A. I think I stated that trying to implement the SSNIP test by using some hard-and-fast rule based on patient flows is inappropriate.
Q. Well, let's think about where patients go for care right now. Okay?

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By your own analysis, about a third of Nampa residents already leave Nampa to get primary care; right?
A. Correct.
Q. Okay. So when a patient is trying to make a decision about where they are going to go to get medical care, there is a variety of factors they weigh; right?
A. Yes.
Q. Like there is convenience, there is reputation, there is price, there is all these factors that ultimately manifest themselves in a decision as to I'm going to go to this particular place; right?
A. Yes.
Q. And so it could be that there is some number of patients where if one of those variables, cost, changed and went up, patients who don't currently travel or leave Nampa might decide, "You know, at that price, I'm going to -- my calculus has changed, and I'm going to switch to a cheaper doctor"; right?
A. The prior empirical evidence suggests that that would be a very, very small percentage.
Q. Which empirical evidence is that?
A. There is the large body of evidence that was developed during the -- prior to selective contracting which suggests that patients weren't responding to price.
Q. I'm sorry. What is the vintage of those studies?

1406

A. These are, I would say, 20 years old or older.
And then the very -- the study in just the past year by Gautam Gowrisankaran and Aviv Nevo that I cited in either my initial report or my expert report which documents very, very minimal price sensitivity of patients within networks, a very, very small elasticity of demand.
Q. You haven't actually done any study of patient price sensitivity in the markets at issue here?
A. That's correct.
Q. Okay. And it's not your testimony that if prices increase, no patients will travel; correct?
A. That's correct.
Q. In order to define a relative geographic market, you agree that the question the court has to answer is not where patients currently go to receive care but where they would go to receive care in the event of a supercompetitive price increase; right?
A. My opinion is that you implement the SSNIP, which is to ask whether or not a hypothetical monopolist in a geographic area could sustain a 5 or 10 percent price increase.
Q. And if we go to slide 26 in your slide deck. This was your representation of where Nampa residents currently go to receive care --
A. Correct.

1407

Q. -- is that right?
And 15.7 percent says "to PCP elsewhere"; 16.4 percent are described as "to PCP in Nampa adjacent zip code." Do you see that?
A. Yes.
Q. Is Nampa adjacent zip code a euphemism for Caldwell and Meridian?
A. I think they might be adjacent zip codes, but there might be other adjacent zip codes, as well.
Q. And you also talked about -- what did you call it? -- your Pac-man slide?
A. Yes.
Q. And you took from this that there was a divide, an east-west divide, between Ada County and Canyon County?
A. A rough divide. As I said, you can identify one or two zip codes where there is a bit more indifference, yeah.
Q. There is also a divide between people who live closer to the highway and those who don't; right?
A. Are you talking about something that's in evidence from this slide?
Q. Yes.
A. So, for example, you're going to have to point that out because I'm not seeing obvious examples just yet --

1408

Q. Sure. How about North Nampa? Doesn't your own slide show that over half the people who live in North Nampa already leave Nampa?
A. That zip code is -- North Nampa is -- if you're talking about the one circle that I had already alluded to where it's much more of an even split, they're also right on the border with Meridian. So I'm not sure if that's a highway phenomenon or simply a local preference phenomenon.
Q. And the one that's a little further up and to the left for Caldwell looks like about half of people in Caldwell already leave Caldwell for primary care; right?
A. Again, though --
Q. Is that right? Is that right, Dr. Dranove?
A. Yes, it is.
Q. And in Meridian, in the two westernmost zip codes for Meridian, it looks like, again, over half of Meridian residents leave Meridian for primary care?
A. That's correct.
Q. And is it your testimony that all these people who are leaving their communities for primary care are doing so for idiosyncratic reasons unrelated to price?
A. I would say the vast majority are doing so, yes.
Q. And is that based in part on your understanding that the prices that these individuals pay for physician services are essentially the same regardless of which

1409

provider in the network they go to?
A. That is one factor.
Q. Now, your diversion analysis which you talked about in your testimony seeks to answer the question of where patients would go for care if a particular provider was withdrawn from the market; is that right?
A. It seeks to answer the question which providers are each other's closest substitutes.
Q. And your diversion analysis shows that if St. Luke's Nampa-based primary care doctors were unavailable, roughly 40 percent of their patients would leave Nampa for primary care?
A. I don't recall if that was what I found, but I'll accept that. That is, they would find that for them their second-most preferred provider after St. Luke's was not a Nampa provider given the current -- the current set of Nampa providers.
Q. But do you recall, Dr. Dranove, in fact, that your diversion analysis shows that if St. Luke's Nampa-based primary care providers were unavailable, roughly 40 percent of their patients would switch to another primary care provider outside of Nampa?
A. Given the current set of providers, if you took away St. Luke's, 40 percent would have as their second-most preferred provider somebody outside of Nampa.

1410

Q. And your analysis shows that if the Saltzer primary care doctors in Nampa were unavailable, roughly 65 percent of their patients would leave Nampa rather than stay in Nampa and see another primary care doctor?

A. Given that you're taking away the providers that account for somewhere close to 70 percent of all the visits, you're going to have to -- within Nampa, there will be a certain set of choices, but those patients are going to now perhaps have to look further afield, some of them.

Q. When you did your diversion analysis and looked at the question of where patients would go if Saltzer was not available, that assumed that St. Luke's Nampa providers would still be available; right?

A. Correct, yes.

Q. And there is no established link, is there, between diversion ratios and measures of market power?

A. That's correct.

Q. And no specific cutoff level above which diversions indicate a high risk of anticompetitive harm?

A. No. The -- the only use of diversion analysis that I know of that seems to be accepted by economists is the question of: Can you establish whether the merging parties are each other's closest substitutes? Beyond that, specific thresholds have not been identified.

Q. You referred in your direct testimony to an

1411

employer that we talked about where you said something to the effect that St. Luke's refusing to be in the second tier is an example of how a powerful provider defeats tiering. Do you recall that?

A. Yes.

Q. St. Luke's didn't defeat tiering in that particular employer's network, did it?

REDACTED

Q. But it still has a tiered system in which St. Luke's is in the out-of-network tier; correct?

A. Correct.

Q. Now, you had access in the course of your work in this case to data produced by Blue Cross and Micron; is that right?

A. Correct.

Q. But you did not study where Micron employees in Nampa went for adult primary care after Micron implemented its new plan in 2008; correct?

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A. That's correct.

Q. And you did not study, for example, the pediatrics market to determine where Micron patients went for pediatric services after Saltzer went out of network in 2008?

A. Correct.

Q. And even though you didn't review that data, you do know that the Micron plan succeeded in incentivizing patients to switch primary care providers; correct?

REDACTED

Q. But you did no analysis of the extent to which Micron patients switched from providers in one tier to providers in another; correct?

A. My interest in the case was to implement the SSNIP, which requires consideration of a 5 or 10 percent price increase, and the price increase for going out of network or going into a lower tier was much more substantial than that. So that information would not have been relevant to my SSNIP analysis.

Q. And that's why you didn't do that analysis?

A. Yes.

Q. So tell me, Dr. Dranove, what would it have cost a -- what was the cost for a Micron employee in 2008 for a primary care visit?

A. I don't recall in 2008 what -- whether they had tiers or what the nature of the contract was.

1413

Q. So we're talking about the new plan, the tiered plan.

A. Okay.

Q. Okay. What were the costs to go see a primary care doctor? Do you know?

A. I seem to recall they were de minimus. They were small if they stayed in network. And there were many -- substantially higher price in percentage terms if they went to a lower tier or went out of network.

Q. Well, can you tell me what those percentages were? Let's take the first two tiers, the most favorable.

A. I can't recall off the top of my head.

Q. Well, you've said it was substantial. I would just like to get some understanding for what you believe to be a substantial --

A. Sure. So I think it might have been, say, you know, for some types of visits, they would be a fixed fee, perhaps $10; versus, say, 20 percent of a visit, which might be $20 if they went out of network, which is 100 percent difference.

Q. Do you know -- when you say "out of network" --

A. To the lower tier, to the next tier.

Q. So is that your -- is that your understanding of what the difference was between the first two tiers?

A. Yeah. My understanding, at least for some

1414

services, was a fixed fee that was small versus a percentage rate and then an even higher percentage rate for out of network.

Q. Right. So my question is: When we're talking about going to see a primary care doctor for a well check, do you have any idea what the price for that was for a Micron employee who wanted to go see somebody in the favored tier but not go to the clinic on site?

A. Again, I seem to recall it was about $10.

Q. And you didn't actually do any analysis to determine the extent to which the price differentials in the different tiers succeeded in incentivizing patients to move from one tier to the other; right?

A. That's correct, but I -- you know, I have given a lot of thought to how the networks affect patient choice.

Q. Thank you. Thank you, Dr. Dranove.

A. Sure.

Q. And you understand the way the cross-examination works, is that --

A. Understood, yes.

Q. -- Mr. Herrick will have an opportunity --

THE COURT: Counsel, let's just get questions before the witness. Proceed.

BY MR. STEIN:

Q. You haven't seen the explicit criteria that Micron

1415

uses to determine whether it has an adequate network of primary care providers; correct?

A. Correct.

Q. Now, you also referred to some testimony from an employer that talked about the Saltzer transaction as potentially being a shockwave.

A. Yes.

Q. Do you recall that?

And that same employer, do you recall some -- do you recall reviewing the testimony of a woman named Jackie Butterbaugh who was affiliated with the company Imagine that put together their network?

A. Only to the level of skimming things.

Q. Well, do you recall her testifying that they were concerned when St. Luke's acquired Boise Surgical Group because they thought that that group was so essential, so essential to the employer's network, that there was no possible way they could continue to have -- have a successful offering without that group?

A. I don't recall that.

Q. You don't recall it?

A. No.

Q. Even if Saltzer and St. Luke's primary care doctors in Nampa are withdrawn from other payor networks, there will still be adult primary care doctors in Nampa --

1416

A. Correct.

Q. -- right?

So, for example, your market share calculations are based on there being 14 primary care providers associated with Saint Alphonsus in Nampa --

A. Yes.

Q. -- right?

And you actually haven't done any analysis to determine whether those Saint Alphonsus providers would have sufficient capacity to treat patients who would be unwilling to -- to travel in the event that Saltzer and St. Luke's documents -- doctors were unavailable; is that correct?

A. That's correct.

Q. Now, with regard to procompetitive benefits, is it your testimony that essentially the economic evidence, the theoretical evidence, is ambiguous about the procompetitive benefits of vertical integration?

A. Yes.

Q. Now, you, yourself, published a study on the impact of hospital physician integration on costs; is that right?

A. I believe that study -- if you're referring to my paper with Federico Ciliberto, the study with the prices, yes.

Q. Prices?

1417

A. Yes.

Q. Let's put that up. That's cross Exhibit 5051.

This is the article that you were co-author of titled "The effect of physician-hospital affiliations on hospital prices in California"; is that right?

A. Yes.

Q. What did you say earlier if we want to see -- if we want to see what's going to happen in the future, look at California?

A. Yes. People often think it's the kind of the canary in the coal mine, so to speak, hopefully, maybe in a positive way.

Q. So on page 3 of this document --

A. Yes.

Q. -- the first sentence under identification, you say, "We want to determine whether vertical integration with physicians is related to hospital pricing."

A. Correct.

Q. That's the question you were trying to answer?

A. Yes. Yes.

Q. And then if we go to the conclusions on page 37 of the article --

George, can we call out the second and third paragraphs of the discussion.

You concluded, quote, "In this paper, we investigate

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whether vertical integration activity affected prices at California hospitals during the 1990s. We find no evidence of higher prices. If anything, integration is associated with lower prices, though the estimated price reductions are neither precise nor statistically significant."

That was part of your conclusion; is that correct?

A. That summarizes a more nuanced set of conclusions.

Q. And then in the first sentence of the third paragraph, you said, "Our results do not support fears that vertical integration may have anticompetitive effects"; correct?

A. This was in response to the paper by I believe it was Alan and Gertler, who were suggesting that even in the absence of market power in the horizontal space, a dominant hospital or dominant physician, that vertical integration can simply, by itself, create anticompetitive effects.

So this is not a general statement about vertical integration in general.

Q. Now, you referred to the fact that there have been other examples of integrated delivery systems that you would -- you would characterize as having failed in the past; correct?

A. Yes.

Q. But there are some integrated delivery systems that have been successful --

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A. Of course.

Q. -- is that right?

And one reason that you think that previous integrated delivery systems failed is that hospitals overpaid for physician practices?

A. Yeah, I think that characterizes some of the acquisitions in the past.

Q. And you haven't done any analysis in this case to determine whether St. Luke's overpaid for any acquisitions; correct?

A. That's correct.

Q. Another reason you think that previous integrated delivery systems failed is that the hospitals lacked the capabilities to effectively manage risk?

A. That's correct.

Q. And you didn't do an independent analysis in this case to determine whether St. Luke's lacks the capability to effectively manage risk?

A. I have seen testimony that they believe they're years away from being able to do so.

Q. You didn't do any independent analysis to make a determination on that point; correct?

A. That's correct.

Q. And there are reasons to believe that vertical integration could be efficiency enhancing; right?

1420

A. Yes.

Q. So, for example, an integrated delivery system might be better positioned to implement complex treatment protocols or promote adoption of interoperable medical records?

A. Some people believe that's true, but I'm not convinced that that is necessarily the case.

Q. Well, do you recall that you said that in your expert report?

A. Yeah. Certainly, some people believe that's certainly possible.

Q. And vertical integration also helps protect the investments that people make in each other?

A. When you look at the pro side of the vertical integration lever, that's one of the things that falls on the pro side.

Q. Right. So one of the benefits of vertical integration, for example, is that a hospital-based group of doctors could, you know, spend the time on things that they might not be compensated for in a fee-for-service environment knowing that they don't have to worry about losing income from that; right?

A. That could potentially be the case if implemented correctly.

Q. And St. Luke's is not alone among hospital systems

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in the country, or even in Idaho, in believing that there are benefits to employing physicians rather than a looser affiliation; right?

A. That's -- yes, that's correct.

Q. In fact, Saint Alphonsus has been increasing its employment of physicians for the last decade or so; right?

A. Yes.

Q. Now, with regard -- with regard to your -- I think you called it your difference-in-differences analysis, and this is where you looked at healthcare spending associated with certain groups that had been acquired and those who hadn't; is that right?

A. Yes.

Q. And you're not opining that prior acquisitions have led to any kind of systematic increase in prices; correct?

A. That's correct.

Q. Do you need more water?

A. Thank you very much.

Okay. Thank you.

Q. And I think you said your analysis doesn't purport to show any exercise of market power; is that correct?

A. Analysis of those prior acquisitions outside of Nampa, yes.

Q. Right. And the way your analysis was structured,

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it was not structured to identify whether there were changes in the utilization rates of services by physicians following their affiliation with St. Luke's; correct?

A. That's right.

Q. And you didn't isolate the purported effects of past acquisitions on the price of hospital services versus physician services?

A. That's correct.

Q. And the difference-in-differences analysis doesn't take into account in any way whether there has been any change in the quality of care provided; is that correct?

A. That's correct.

Q. The lack of an integrated electronic medical record is one of the reasons that integrated delivery systems have failed in the past, isn't it?

A. I think I wrote about or actually testified once about this, referring to integrated delivery systems in the 1990s. And I would certainly say that in the 1990s, that was a major problem.

Q. And the implementation of the Epic medical record and the WhiteCloud data analytics tool that St. Luke's is implementing might facilitate the kind of cost reductions that have eluded integrated delivery systems in the past; right?

A. It might.

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Q. Would you agree that if the Saltzer transaction facilitated the development of an integrated electronic medical record, that would be a procompetitive benefit?

A. I wouldn't agree with such a blanket statement.

Q. Why not?

A. Thus far, the evidence suggests that the option of electronic medical records has not actually led to a reduction in expenditures on average. So while it might be procompetitive, the evidence to date suggests that it won't be.

In addition, we are making great strides in providing opportunities for providers with independent electronic medical records to communicate with each other so, going forward, we may be able to get the benefits of electronic medical records if they're out there through independent agencies. I just think this is a big black box at this point.

Q. Right. Nobody knows whether that's going to be possible or when that might occur; right?

A. I think right now nobody knows when electronic medical records, whether integrated or not, are going to fulfill their promise.

Q. Well, your own research demonstrates that there are hospitals that implement electronic medical records that can enjoy cost savings of 2 to 4 percent; right?

1424

A. You're talking about my paper with Shane Greenstein, et al.?

Q. I'm talking about your paper titled "The Trillion Dollar Conundrum."

A. Yeah, that's the same paper.

Q. Right.

A. Would you like me to say more about that paper?

Q. No. I would just like you to answer my question, which is --

A. Could you repeat the question.

Q. Your paper concludes that some hospitals can enjoy cost savings of 2 to 4 percent with the implementation of electronic medical records.

A. Yes, some hospitals can do that.

Q. And you believe that even hospitals that are -- that don't have necessarily the best complimentary IT capabilities will start to experience those benefits in the future; is that right?

A. We're hopeful that those benefits will be enjoyed down the road, yes.

Q. And you testified earlier, I think, that you wrote a couple of books; is that right?

A. Yes.

Q. At least a couple of books?

A. Yes.

1425

Q. You've written several. You've written, what, half a dozen books?

A. Roughly, yeah.

Q. And am I right that the most recent book you wrote was called "Code Red"?

A. My most recent book, I hate to say it, is the "Sixth Edition of the Economics of Strategy," which is a strategy textbook. But prior to that, it was "Code Red," yes.

Q. Okay. And in that book, you wrote that it's literal exaggeration to say that every other major ongoing health initiative depends on the success of electronic medical records; right?

A. I missed -- can you say that again.

Q. Certainly. I'll tell you what. If you look in your binder there under 5055 --

A. Okay. And just point me to a page. Did you say it's little exaggeration? I just didn't get the adjective.

Q. Sure.

A. Yes. 5055.

Q. I'll ask you the question again, Dr. Dranove. But this is your book?

A. Yes.

Q. So on page 211 --

A. Okay, yes. Okay. I'm sorry. I just didn't hear

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the adjective "little."

Q. I understand. Let me reask the question. You wrote, quote, "It is little exaggeration to say that every other major ongoing healthcare initiative depends on the success of EMRs. EMRs must be our top priority." That's what you wrote; correct?

A. Yes, I did write that.

Q. Okay. And you also wrote on page 207 there at the end of the last paragraph at the top of the page, quote, "If we want to make any significant progress in reforming the health economy, we must standardize and broadly implement electronic medical records; correct?

A. Yes.

Q. And, in fact, you have proposed on your blog that the government actually implement standards to enforce compatibility among different medical records --

A. Yes.

Q. -- right?

And you believe that with that enforced compatibility or with compatibility, we will see rewards for quality and efficiency that can be driven by market forces?

A. I no longer believe that the government needs to enforce this compatibility. Exchanges are being set up that's creating compatibility without government intervention.

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Q. Have you done a study of what's capable and not capable under the Idaho Health Data Exchange?

A. No, I have not.

Q. So in the absence of -- but the reason you think an exchange is important is because you believe that the exchange will allow for the interoperability of those medical records?

A. I think it will allow for providers to remain independent and allow us to enjoy all the benefits we get from independent providers while also achieving the benefits of information exchange through electronic medical records.

Q. The benefits of independent providers?

A. Yes.

Q. What are the benefits of independent providers?

A. As I describe in my economics of strategy book and laid out in my expert report, vertical integration is not a one-way street, that when you -- for example, when you employ physicians, those physicians who used to be entrepreneurs responsible for developing their own practice and maintaining relationships with their patients now become employees.

And we have seen that that's had incentive effects on providers. They haven't worked as hard to maintain their employees, and this can have potentially deleterious effects on the production of medical care.

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Q. So do you believe the independent business model is a better business model than employing physicians?

A. No. Again, I think there is two sides to this equation. There are pros and there are cons.

Q. You're not offering an opinion that St. Luke's would be able to achieve the same benefits with Saltzer in a looser affiliation as it would if the transaction proceeds; correct?

A. The benefits of EMR?

Q. No. Procompetitive benefits generally.

A. I haven't identified any procompetitive benefits to date, so I don't know how to answer that question.

Q. Well, you said, hypothetically, if there were procompetitive benefits, you would be concerned about whether they could be achieved with a looser affiliation.

A. Yes.

Q. You haven't done any kind of analysis to determine whether, in fact, St. Luke's could achieve the procompetitive benefits through a looser affiliation?

A. No.

Q. Now, you also referred to Advocate in Chicago as a mixed model?

A. Yes.

Q. What do you mean by that?

A. That means they employ many physicians, but they

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also have many physicians who admit patients to Advocate who are not simply just third party -- they admit a patient and otherwise don't engage in the clinical life of the applicant. They serve on committees. They help develop protocols. They exchange information through electronic medical records. So they are more loosely integrated with Advocate and, in particular, they're not financially integrated.

Q. Well, St. Luke's also has a mixed model; correct?

A. That's correct.

Q. And when you talked about vertical integration, I think you said something to the effect -- and correct me if I'm wrong -- that your analysis shows that it's not clear whether past transactions have resulted in unlocking the key or something like that.

A. That was a very bad metaphor. You don't unlock keys; you use keys to unlock doors. Let's say we have not seen a consistent ability to -- to find efficiencies through vertical integration.

Q. But would you agree, then, that one of the things that the court needs to do in this case would be to listen to the testimony that comes in from both sides here and decide whether -- whether the Saltzer transaction will be successful in unlocking the door to the kinds of benefits that can be achieved with vertical integration?

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A. I agree.

MR. STEIN: I don't have any further questions at this time, Your Honor.

THE COURT: Redirect, Mr. Herrick. While you're getting up, perhaps I could ask a question.

EXAMINATION

BY THE COURT:

Q. Dr. Dranove, if I understood your testimony earlier in terms of procompetitive effects, you indicated that you weren't able to identify any based upon the existing data.

A. Yes.

Q. And that, of course, one of the things that we have heard about is, you know, the idea of converting kind of the overall model for healthcare so that perhaps the idea of vertical integration, as it's applied or whatever benefits may be derived under a fee-for-service world, is it your view that we simply don't know enough about what risk-based contracting would do to really formulate whether there is any procompetitive effect from that? Or do you believe that there is enough data to actually analyze that and still conclude that there is no procompetitive benefit from the proposed acquisition?

A. Your Honor, this case reminds me intellectually of the situation in the 1990s when, at that time, integration

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was all the rage. And a pass, I think, was given to integrating provider organizations with the view that integration was a panacea. It almost became the end rather than the means to the end. If we integrated, we have accomplished our healthcare policy.

And as a result, we saw a substantial number of mergers get through the courts, mergers that we have now seen through lots of research studies produced higher healthcare spending without offsetting benefits.

And I feel like we once again got really excited. We are caught up with the idea that we need to do something to change the system because we don't like the status quo. Integration has again been offered as the solution. Yet, there is this notion of déjà vu; we have been here before. I think we are running before we have learned how to walk, and the result may be that we end up with a concentration of market power and, yet again, not any -- any benefits to offset that.

And in this case, it's not as if they don't have an integrated model. They have the opportunity to have a mixed system already, to run the system for two or three years and bring new data to bear. And if the new data shows that they are reducing healthcare spending, I'm going to do the same type of analysis. If I was asked to be the expert again, my testimony would be quite different.

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Q. Well, that kind of leads me to at least one, maybe two additional questions.

The first would be, you know, we're a small market. And you alluded to the fact that California is the canary in the coal mine. I'm not sure that's the way they would want to describe it.

A. They're the pioneers.

Q. The pioneers.

A. The forty-niners.

Q. That's the safer term. I have to assume that there are regions, markets that are, as in many things, years ahead of our state. And I wince when I say that, as well, but -- so do we -- is there any experience where there has been enough --

A. Sure.

Q. -- development of this to actually begin to start forming some opinions? Not just about integration because I think integration is one piece of it. I think the argument or suggestion is that it's not just integration; it's changing the way we think about reimbursement.

A. Sure.

Q. Which, in turn, means we have to change the way we think about how economics applies to this market.

A. Let me give you two examples, one going either way.

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Q. The second question, before I forget it, is: If there are examples out there, are they sufficiently distinguishable because of economic or market forces from where we are to say that that either is or is not a good predictor of what may occur here? So there's two questions there.

A. Those are good questions. Let me give you two examples that kind of work in opposite directions. There's the well-known example of Kaiser.

Q. I was actually going to use Kaiser as an example.

A. Kaiser is a remarkable success story. Kaiser is successful in part because the physicians it employs have a different mindset. A lot of people have observed they hire a certain type of physician. They don't just look at the physicians in the market and hire whoever is out there. They hire a certain type of physician who practices medicine in a different way.

They have enrollees who are willing to embrace the Kaiser model. And I should say, despite Kaiser's success, their market share has been 30 percent for the past, like, 15 years. So some people like it, most people don't, even though it's a lower cost way of delivering medical care.

And when Kaiser tried to move out of the West Coast, they were not as successful. They couldn't find those physicians in other markets. So there is that model.

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It's a fabulous model, and it works. There is no blueprints for copying it.

Then there is also the example of alternatives to integration to create risk-based contracting. The Pacific Business Group on Health, which is a consortium of major employers in Southern California, has worked in conjunction with PacifiCare, a major employer in Southern California, to implement pay-for-performance, quality bonus metrics in Southern California.

So it shows that it's possible for an independent insurer to do that. You don't have to be integrated. Sadly, just as the Kaiser story has both a good and a bad side to it, this has a good and a bad side to it, as well. The experience of PacifiCare is consistent with what we have seen elsewhere. It's been very hard to implement these pay-for-performance schemes and avoid some unfortunate unintended consequences.

So, even in California, they're still trying to work these things out.

Q. Okay. I think you indirectly answered the second part of my question, which is that maybe the programs don't travel well.

A. I think it's hard to say right now how well the programs travel. Minneapolis is another market where employers have been very, very involved working with

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providers in the delivery of medical care. Yet, we have seen -- yet, we have really failed to see that model travel into other markets.

Q. Okay. Even if that were the case, as big as Micron may be in the Treasure Valley, it's probably not large enough to successfully pull off something like that that, say, a --

A. We're talking about consortium. We're talking about trust that's been built up in Minneapolis, which is the home of HMOs where, at a time when there wasn't an HMO backlash, this type of relationship, this type of mindset by providers has been in place for a long, long time.

Q. Okay. Thank you.

A. But there are just no -- I wish there were panaceas that we could offer, but there aren't.

Q. I think the whole world is looking for a panacea how to solve the healthcare problems, which indirectly is why we maybe are facing a shutdown of the federal government because of those same battles.

THE COURT: Mr. Herrick.

MR. HERRICK: Thank you, Your Honor.

REDIRECT EXAMINATION

BY MR. HERRICK:

Q. Professor Dranove, if you'll forgive me, I am going to jump around a little bit.

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THE COURT: Counsel, we are going to take a break in ten minutes or so, but let's use that time.

BY MR. HERRICK:

Q. First off, Professor Dranove, Mr. Stein asked you a lot of questions about your analysis, I think was the term that he used. When you use the term "analysis," does that have a specific meaning in your mind?

A. I think he said independent analysis. And in my mind, I was thinking of actual studies with data.

Q. And does -- if you say that you didn't perform an independent analysis, does that mean you didn't consider any evidence on that particular subject?

A. No. I would have reviewed the documentary evidence, testimony, and economic theory.

Q. Mr. Stein also asked you some questions about pricing.

A. Yes.

Q. Do you have an opinion on the relative magnitude of the harm to competition and whether that would be significant in this case?

A. I think the size of the Nampa market combined with the increase in bargaining leverage that will result due to the underlying market share suggests that this will not be a de minimus change in market power, which I would never worry the courts about. This is a substantial increase in market

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power that's likely to result in substantially increasing revenue.

Q. The phrase "de minimus" is an interesting one. So when Mr. Stein asked you about the example of the 999 -- 1,000th largest providers in a market, does that accurately reflect what we're seeing here?

A. No, obviously not. These are the first and second largest and each other's closest substitutes.

Q. And why does that matter in terms of your conclusions?

A. If -- this really was going to have just a very, very small effect on prices. The amount that we have spent in the court today on trying to decide this case could not possibly offset any increase in prices that we would have observed. That would be a silly use of the antitrust laws.

We should apply the antitrust laws when we're concerned about substantial increase in the market power, such as in this case.

Q. Mr. Stein also asked you a series of questions relating to BCI's bargaining leverage.

A. Yes.

Q. Do you recall that?

Can you compare BCI's bargaining leverage before the transaction and after?

A. It would be the same.

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Q. And is BCI the only entity that you believe will be disadvantaged by this acquisition?

A. I think every employer that uses BCI is going to see their rates go up, and the same thing for employers who use other health insurers in the state.

Q. And that's true of other health plans, as well?

A. Yes.

Q. What about consumers?

A. I mean, it is well known from economic theory and evidence that when health insurance premiums go up, wages go down. Employers can't afford to give the same package of wages and benefits as they used to. So that's a huge impact. And then, of course, if you're paying even a 10 percent copayment, that will lead to a small additional increase in your expenditures.

Q. Mr. Stein also asked you some questions about your two-stage model of competition. Do you recall that?

A. Yes.

Q. And there was, in that part of your examination, some discussion of tiering networks or tiered networks.

A. Yes.

Q. Earlier in your testimony, you explained how bargaining leverage works in these kinds of markets. Do those same dynamics apply in tiered networks?

A. Of course. If an insurer wants to have tiers,

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there is going to be a price at which a provider is going to get into the best tier. And that's based on the fact that if the insurer leaves out of the best tier, it's going to have to convince employees to go into the second-best tier or the third-best tier. Then there is a price to be in the second-best tier, which is based on the employers having to tell the employees you have to go into the third-best tier.

If the attractiveness of the next-best tier is lessened because the two parties are now negotiating jointly, Saltzer and St. Luke's, that will increase the price that they can get for whichever tier they slot themselves into.

Q. So if more employers adopted a tiered network in the Treasure Valley, would that change your conclusions about the competitive effects here?

A. No. I think it might lead to lower healthcare spending overall. However, I would think that, one, you might see less adoption of tiering, especially if St. Luke's and Saltzer refuse to participate in a tiered network; or if the trend continues and we see tiering, the pricing in those tiers will be higher as a result of the merger.

Q. When you say the pricing in those tiers, are you referring to the price to --

A. Saltzer --

Q. -- be in network for Saltzer and St. Luke's?

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A. Saltzer and St. Luke's, yes.

Q. And that would be the price that either the employer or the consumer ultimately pays?

A. Yes.

Q. And this may be just a matter of nomenclature, but is the same true of narrow networks?

A. I think that's just nomenclature, yes.

Q. So, just to be perfectly clear, when you're talking about tiering or tiered networks, the same concepts apply to narrow networks?

A. Yes. So we have this backdrop -- it's happening slowly, maybe it will accelerate -- of tiering and narrow networks affecting healthcare spending. St. Luke's and Saltzer's position in the future of medical care will be better as a result of this merger than it would be without the merger because, once again, they gain increased leverage regardless of what it is the insurers are trying to do.

Q. Mr. Stein also put one of your slides back up on the screen which showed a pass-through of, you know, bargaining leverage to out-of-pocket costs for consumers.

Are there other ways in which this acquisition, in your opinion, would likely harm consumers?

A. Sure. You know, a lot of insurers like the Pacific Business Group on Health -- and it's working through PacifiCare -- have been trying to impose risk-based

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contracting, pay-for-performance quality metrics. A powerful provider can resist doing this.

In fact, there was a series of articles about health -- changes going on in the Ohio marketplace back in the 1990s when the largest insurer in Ohio attempted to put in a quality report card. And a dominant provider -- I can't recall whether this was the Cleveland Clinic; I think it was the Cleveland Clinic, but it might have been University Health -- refused to participate, says: We're not going to allow you to publish our report card scores. If you want us to be in your network, you can't publish. And that torpedoed the effort to do quality scoring.

Q. Mr. Stein also asked you some questions about your diversion analysis. Just to make sure I understand your testimony, is a diversion analysis the same as the SSNIP test or the hypothetical monopolist test?

A. No. Again, the diversion analysis is kind of a nuanced add-on to the market share analysis. So to implement the SSNIP, I think the typical approach is to simply look at market shares and market concentration.

But economists in recent years have suggested -- and I think it's a good suggestion -- looking at whether the particular merging parties are close competitors, not are they Toyota and Honda or Toyota and BMW.

Q. So does diversion analysis, in your opinion, tell

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you how many patients would switch in response to a SSNIP?
A. No.
Q. A couple of questions about Micron. Mr. Stein asked you a series of questions on that and particularly on the various fees that might be paid at the different tiers within Micron's health plan.
In preparation for your testimony today, did you attempt to memorize the fee schedule for Micron in 2008?
A. No, I did not. I think as we have seen today, my memory is not always the most reliable thing when it comes to details like that.
Q. But in forming your opinions, did you review information about Micron's network and its -- in testimony on that?
A. Yes. So what I was interested in is kind of the relative magnitude of the price differences. Are these 5 percent differences or 50 percent differences? And when I reviewed the network structure, they looked more like 50 percent differences, not 5.
Q. Shifting gears yet again. Mr. Stein asked you a series of questions about employment of physicians. And given your experience and analysis in this particular case, including your background as a healthcare economist, do you believe that employment of physicians is necessary to achieve the kinds of benefits that are being claimed by

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St. Luke's experts here?
A. I think I'd put it differently, that employment might increase the chances of achieving some benefits while creating other costs at the same time.
So, for example, I talk about in my expert report getting physicians to make investments in their organization. If you employ them and you have the right central office that rewards physicians who make those investments, you might be able to get more of those investments.
But I also talked about the offsetting costs of taking entrepreneurs and making them dedicated salary employees.
Q. So, in connection with that discussion, I believe -- I may be mistaken -- Mr. Stein also asked you about various other healthcare service providers, and you had mentioned Advocate --
A. Yes.
Q. -- as one example. Do you recall that?
A. Yes.
Q. And do you have a sense of the relative magnitude of the number of employed physicians that Advocate works with versus independent physicians?
A. I think they are fairly comparable, both substantial numbers.

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THE COURT: Counsel, this is about where we take the morning break. Is this a good breaking point? I was not sure if you were wrapping up or going on to another topic.
MR. HERRICK: I'm quite close to being finished. I don't know how much more time Mr. Stein is going to need.
THE COURT: Well, why don't we take the break, then, and come back in 15 minutes.
MR. HERRICK: Very well. Thanks.
THE COURT: We'll be in recess for 15 minutes.
(Recess.)
***** COURTROOM REMAINS OPEN TO THE PUBLIC *****
THE COURT: Dr. Dranove, I'll remind you you are still under oath.
Mr. Herrick, you may resume your redirect examination.
MR. HERRICK: Thank you, Your Honor.
BY MR. HERRICK:
Q. Dr. Dranove, Mr. Stein asked you a series of questions about your difference-in-differences analysis. When you engaged in that analysis, what were you trying to measure?
A. I was looking at total healthcare expenditures, which, of course, involves both prices and quantities.
Q. And the results of that analysis were what?
A. That the acquisitions, prior acquisitions of

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primary care physicians did not seem to be associated with a reduction in total healthcare expenditures.
Q. Now, Mr. Stein asked you whether you isolated, I believe is the term Mr. Stein used, the effect of utilization in your differences analysis. Does your difference-in-differences analysis account for changes in utilization?
A. Sure. So total expenditures could go up or down because utilization changes or prices change. So if there was, say, a substantial reduction in utilization but no change in prices, that would have shown up in my analysis as a reduction in expenditures.
Q. Let me put it slightly differently. If St. Luke's acquisitions had generated meaningful improvements in utilization, would that have been reflected in your analysis?
A. Again, if it had generated meaningful reductions in utilization without offsetting increases in prices, I would have observed reductions in expenditures.
Q. Shifting gears yet again, you had a brief discussion with the court, and you mentioned the example of Kaiser Permanente as an integrated system, if you will. Are there any counter examples that you can think of of integrated systems that maybe haven't been quite so successful?

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A. Yes. So there are success stories, but there are failures. Perhaps the poster child for when things go awry is the Allegheny Health Education and Research Foundation, which was a very large integrated system that was formed in Pennsylvania in the 1990s that ultimately became what was at the time the largest nonprofit bankruptcy in U.S. history.

Q. Last but not least, Professor Dranove, Mr. Stein asked you about an article you wrote with Mr. Ciliberto. Do you recall that testimony?

A. Yes.

Q. And I'm not trying to put words in your mouth, but I think you used the word "nuances." Can you elaborate on what you meant by that.

A. Sure. That paper looked at the effects of integration on physician prices. And we found that, on average, we didn't see any statistically-significant trend one way or the other. However, to the extent that we did see anything, it was kind of interesting. We looked at three different or four different levels of integration, from financial integration, where the physician practices were acquired by the hospitals, to looser forms of affiliation that have in the literature been described as integration, but they are not financial integration.

And the one form of integration that did -- that was associated with lower prices was the loosest form of

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integration, not financial integration, but at the other end of the spectrum.

Q. Is there a table or a summary in your -- in that article that reflects the more nuanced results?

A. Yeah. The last full table of statistical results -- I don't recall the table number -- shows the changes in prices for each of the different types of forms of integration and shows the price reductions for the loosest form.

Q. On the other end of the scale in that table, do you recall where full financial integration fell?

A. I don't recall how far it fell in the other direction, but I seem to recall that, if anything, it was price increases, but I don't think it was necessarily statistically significant.

MR. HERRICK: Thank you, Dr. Dranove.

Your Honor, I have no further questions at this time.

THE COURT: Any recross?

MR. STEIN: No, Your Honor.

THE COURT: Dr. Dranove, you may step down. Thank you very much.

MR. HERRICK: Your Honor, we do have one sort of housekeeping matter relating to Dr. Dranove's testimony.

THE COURT: Yes.

MR. HERRICK: We provided his expert reports as

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exhibits, and we would like to move those into evidence.

THE COURT: Is there going to be any objection?

MR. STEIN: Absolutely, Your Honor. We do not agree to the introduction of the reports.

THE COURT: All right. Then I will have to sustain the objection on hearsay grounds and others, but, obviously, that will apply equally, that no expert reports will come into evidence other than the testimony itself.

MR. HERRICK: Very well, Your Honor.

THE COURT: What's the exhibit number so I can note that for the record?

MR. HERRICK: Those are, I believe, 1848 and 1849.

A somewhat related issue, Your Honor, once you've had a chance to write those down. There are a series of figures and exhibits that were part of Dr. Dranove's analysis, and we separately identified those as exhibits to be potentially moved into evidence. Our understanding is that defendants have also done a similar approach for their expert reports. So we would, again, move those exhibits into evidence separately from the actual reports.

THE COURT: What are they? Do they have a separate exhibit number?

MR. HERRICK: It's quite a lengthy list. And there is sort of one continuous theme. It's a 702 objection with a couple of exceptions. It's basically 702 over and

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over again.

MR. STEIN: Your Honor, if I could -- as a general matter, I think with this witness, we would probably not have an objection to most of the figures. I would like a chance to take a look. The reason I hesitate is because this is going to be an issue more for the witness tomorrow. So I don't want to just say we won't object to the admission of any of the exhibits that were attached to their reports because there may be, for example, analyses in the reports or in the figures that are simply not testified to in court.

So perhaps what -- we could take an opportunity, now that we have the testimony in, to look at the list and possibly just withdraw our objections to a number or maybe all of those exhibits.

MR. HERRICK: We'll confer with defense counsel and come back to the court.

THE COURT: Perhaps even submit a written list of what the exhibits are and what the objections are or are not, and then I can so note them tomorrow morning.

MR. STEIN: Thank you, Your Honor.

MR. HERRICK: Thank you, Your Honor.

THE COURT: On that same issue, there were three or four items, Mr. Stein, that you referred to. I think they were prior written documents from Dr. Dranove that I think were simply marked, but you weren't offering them.

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They were just being used for impeachment; correct?
MR. STEIN: That is correct.
THE COURT: As long as they're well enough identified in the record -- in other words, the question, the location where the document came from, what the text was that you were referring -- I don't know that we need to mark it to make it part of the record, but I'm willing to hear --
MR. STEIN: We could if Your Honor would like that. It wouldn't be difficult.
THE COURT: I noted you have numbered them with like 5,000 something.
MR. STEIN: We just picked a range so that we could identify them.
THE COURT: Mr. Herrick, what's your preference in that regard? As long as the record is clear as to what was being referred to and there is a reference by volume, page, et cetera, then I'm comfortable the record is clear, but if not, we may want to have those marked as well, not as an exhibit, but simply for the record.
MR. HERRICK: That sounds fine to us, Your Honor. The only potential issue is that I believe one of the exhibits that Mr. Stein used had Dr. Dranove's social security number on it. So to the extent that was going to be made part of the record --
THE COURT: Obviously that would need to be

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redacted, so --
MR. STEIN: Unfortunately, that was actually from the court file, that document, so -- but we're not going to introduce -- we don't need to introduce that.
THE COURT: How did we in the court file have his social security number on --
MR. HERRICK: That's a very good question. This is not something that we filed.
MR. STEIN: It was an invoice that was attached to a bill of costs that was submitted by somebody in the other case, and it was not -- I mean, it was several years ago.
THE COURT: It may have been enough years ago that the E-Government Act had not yet come into effect.
MR. HERRICK: I believe it was 2005, if memory serves.
THE COURT: All right. Well, let's clean that up regardless whether -- obviously, today, the E-Government Act is in effect, and we need to make -- be careful.
All right. If you will indicate and submit, I guess, to Ms. Gearhart the exhibits that you referenced, they were noted for the record. I'm not going to admit them, but we'll just make them part of the record, not as an admitted exhibit but as one simply referenced similar to a demonstrative. All right?
MR. STEIN: Yes. As long as we're talking about

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exhibits, Mr. Powers and I were also talking, we have got these demonstratives, and I know Your Honor said he would take the slides. Should we just submit those to Ms. Gearhart? Do those need to be numbered? How do we take care of those?
THE COURT: They need -- when -- and, again, it may have been an oversight on my part, but when the witness was on the stand and there is a reference, there should have been a reference somehow during the examination so that we could identify that for the record so that the appellate court would know precisely what the witness was looking at when those questions were being asked.
If that was not done, you may try to remedy that as best you can, at least identify what the exhibits were that were being used during that witness's testimony. And, I think, going forward we need to be perhaps a bit more careful on that -- on both topics. If you're using documents for impeachment, don't intend to offer it but simply want to have the witness look at it, then we need to make -- apparently the 5,000 series will be used for that purpose by St. Luke's, and perhaps the plaintiffs can use the 4,000 series or something to identify those documents. All right?
MR. HERRICK: That sounds very manageable, Your Honor. In terms of Dr. Dranove's demonstratives, I

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assume the same practice should apply.
THE COURT: Yes, yes.
MR. HERRICK: Okay. Thank you, Your Honor.
THE COURT: All right. Call your next witness.
MS. DUKE: We're going to continue with the deposition of Mr. Roth, and that was AEO.
THE COURT: All right. We'll have to ask that -- does everyone need to leave, or are there some --
MS. DUKE: St. Luke's is able to stay.
THE COURT: All right.
****** COURTROOM CLOSED TO THE PUBLIC ******
MS. DUKE: Okay, Your Honor. May I proceed?
THE COURT: Yes. Well, we haven't quite cleared the courtroom.
MS. DUKE: And we're starting back up on page 156.
(Continuing testimony of Christopher Roth via video deposition.)
(Video deposition paused.)
MS. DUKE: Your Honor, just for the record, the exhibit that's being referenced is Exhibit 1083, and that's when he references page 10 and page 13 of what he just testified to.
THE COURT: Counsel, I was actually thinking of that when we first pulled up an exhibit.
MS. DUKE: And the reason is when people were

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cutting these, they cut the first four lines of that section, which would then turn you to Exhibit 102 in the deposition, which was Exhibit 1083, and that's the document. So I'm not sure how else to clear the record than that.

THE COURT: I wonder --

MS. DUKE: It will be clear in the transcripts that will be filed.

THE COURT: It will be because the exhibits will be attached; correct?

MS. DUKE: Well, they will be referenced with the trial exhibit number.

THE COURT: Okay. So the hard copies of the transcript will reflect the actual trial exhibit number --

MS. DUKE: Correct.

THE COURT: -- by some type of --

MS. DUKE: A line through the depo exhibit number and the trial exhibit number written.

THE COURT: That's sufficient. As long as that's done, I don't think we need to worry about it.

MS. DUKE: All right. Thank you.

(Video deposition resumed.)

(Video deposition concluded.)

MS. DUKE: Your Honor.

THE COURT: Yes.

MS. DUKE: We are going to move now to Mr. Taylor,

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who is also AEO.

THE COURT: All right. So we'll just keep the courtroom closed. The same, the St. Luke's executives can remain in the courtroom. All right.

(Testimony of Jeff Taylor via video deposition.)

MS. DUKE: That's the conclusion of Mr. Taylor.

THE COURT: That's got to be almost a world's record.

MS. DUKE: I am trying to put these in order a little bit for AEO purposes, Your Honor, just so we can get some of the AEO handled while folks are out.

THE COURT: All right.

MS. DUKE: So just give me one moment.

THE COURT: Yes, certainly.

MS. DUKE: And there will be a little bit for Mr. Roth. It's just for some reason his video blanked out, so I went right to Taylor to keep this moving. We'll get back there.

THE COURT: Okay.

MS. DUKE: We have next Mr. LaFleur. With Mr. LaFleur, Your Honor, there will be a joint exhibit filed tomorrow that St. Luke's counsel and plaintiffs' counsel have agreed to. And what it is, is a highlighted version of much of the foundation that St. Luke's requested be submitted to the court related to some exhibits on the

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plaintiffs' exhibit list. So we will file that joint exhibit with our next joint exhibit number tomorrow morning, just so Your Honor knows the agreement that was reached.

THE COURT: All right. Thank you.

(Testimony of Peter LaFleur via video deposition.)

(Video deposition paused.)

MS. DUKE: We can open the courtroom at this point, too, Your Honor.

THE COURT: I'm sorry?

MS. DUKE: We can open the courtroom at this point, as well.

THE COURT: Let's go ahead and do that. How long does this video take or this recording?

MS. DUKE: This one is six minutes long.

THE COURT: All right.

****** COURTROOM OPEN TO THE PUBLIC ******

(Video deposition resumed.)

(Video deposition of Peter LaFleur concluded.)

MS. DUKE: All right, Your Honor. The next video will be Gary Fletcher, and that is about 18 minutes long.

THE COURT: Counsel, were there any -- I don't think there were any --

MS. DUKE: There are exhibits that are referenced. They're in the filing that you're going to receive that came in by an agreement by the parties.

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THE COURT: All right.

MR. SCHAFER: With respect to those exhibits, I think we still have some objections to certain of the exhibits. We have withdrawn, based on the filings, the foundation objections, but we still have -- I don't have the numbers, but we have objections to some of the remaining exhibits that are sought to be introduced. I just wanted that to be -- right? I think Michael had those conversations with Mr. Keith, but that is the understanding; correct?

MR. HERRICK: Yes. There is a certain number of exhibits that were not previously objected to. Defendants raised an objection to them after seeing the final deposition designations. And there is -- we're referring to that subset of exhibits that had not previously been objected to. There was a new foundation objection. We have since resolved that through this process.

MR. SCHAFER: But there are still some remaining objections to those exhibits and their admission on other bases.

MR. HERRICK: There a few foundation objections where there were previous nonfoundation objections. Those are still in play.

THE COURT: Okay. Counsel, I'm afraid this is kind of spiralling out of control. How am I going to make

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the ruling? It's very difficult to make a ruling two or three days later after the witness has testified. It's one thing if they're stipulated to; that's a very simple matter. But if they're not and I have to make a ruling, I need to make a somewhat contemporaneous ruling just so it's fresh in my mind.

Now, can we be more clear? Are we talking about the exhibits that are going to be used with Mr. Fletcher's deposition or some of the earlier depositions or a combination thereof.

MR. SCHAFER: I believe they relate to Mr. LaFleur, the video that just played.

THE COURT: Mr. LaFleur.

MR. HERRICK: Your Honor, if I may clarify. There were a large number of exhibits that were on both sides' witness lists that were not objected to, and those have been moved into evidence by stipulation, the files that were filed last week.

THE COURT: Correct.

MR. HERRICK: The exhibits that we're referring to with respect to Mr. LaFleur are part of that category only.

THE COURT: So they were admitted, and now St. Luke's is seeking to withdraw from its stipulation?

MR. HERRICK: Without going into a lot of detail back and forth and discussions we had with Mr. Metcalf,

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that's in essence the detail. So we have moved -- the category of exhibits that have been moved into admission are only those that on the witness lists that were filed by the parties have not been previously objected to. There are other exhibits in Mr. LaFleur's deposition that we have not yet moved into evidence. That's the category that Mr. Schafer is referring to now.

THE COURT: Well, are they -- were they exhibits that were not stipulated to originally?

MR. HERRICK: That's correct. There were objections that were originally made, and there was a foundation objection added.

THE COURT: And how is that going to be teed up for me so I can rule?

MR. HERRICK: We are not seeking to admit those at this time. There is a large number of exhibits on both parties' exhibit lists that relate to many, many depositions, not just Mr. LaFleur's. We have a plan to meet and confer regarding those larger issues and how we may be able to resolve some objections from both sides. We plan to do that later today and don't yet have a resolution as to the broader category of exhibits.

THE COURT: All right. Well, I guess that's the best we can do. Let's go ahead and press forward. But I'm just telling you it is difficult -- if you have a series of

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objections that I need to resolve concerning testimony that was given last week, it's very hard for me to remember what was testified to and make any kind of a ruling. So good luck. You may -- I may, just by default, admit it all, and then you can go up and argue to the circuit and get it reversed, and we can do this all over again.

Let's go ahead and proceed.

MS. DUKE: So this is Mr. Fletcher.

THE COURT: All right.

(Testimony of Gary Fletcher via video deposition.)

(Video deposition paused.)

MS. DUKE: Your Honor, that exhibit has been objected to. It's Exhibit 1136.

THE COURT: Yes. I have that note as --

MS. DUKE: We would be moving for its admission.

THE COURT: -- 403. Is there an objection?

MR. SINCLAIR: Just a second, Your Honor. I'm getting a copy to look at.

THE COURT: Yes.

MS. DUKE: If it helps, Walt, the only objection noted was 403 on the list.

MR. SINCLAIR: Right. What is the document?

MS. DUKE: The one that we have just been going through, the email referencing Dr. Bathina.

MR. SINCLAIR: Right. I am familiar with this

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email string from other depositions. We'll withdraw the objection.

THE COURT: Exhibit 1136 will be admitted.

(Plaintiffs' Exhibit No. 1136 admitted.)

MS. DUKE: And this exhibit is AEO, Your Honor.

THE COURT: All right. We'll need to clear the courtroom then. Everyone except St. Luke's, I assume?

MS. DUKE: Yes, Your Honor.

****** COURTROOM CLOSED TO THE PUBLIC ******

(Video deposition of Gary Fletcher resumed.)

(Video deposition of Gary Fletcher concluded.)

MS. DUKE: All right, Your Honor. That's the conclusion of Gary Fletcher's portion.

THE COURT: Just a moment. Give me a moment. I'm sorry, Counsel. I just wanted to make a note while I was thinking.

MR. WILSON: Your Honor, would your preference be -- the screen at the bottom shows which trial exhibit number is --

THE COURT: Yes. That's what I'm referring to.

MR. WILSON: So we don't need to --

THE COURT: Well, except --

MR. WILSON: Those are admitted.

THE COURT: True. I'm checking and I think in each instance with the exception of 1136, which we just

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dealt with -- if I'm not, Ms. Gearhart is. She is very good at tracking those things as well. So we are tracking there. We dealt with the problem of making sure that the exhibit number, which isn't referenced in the deposition, will be handled with the written transcript, which will be submitted and part of the record; correct?

MS. DUKE: Yes.

THE COURT: In fact, the exhibits -- the depositions which we published, though, will not include those cross references.

MS. DUKE: Correct.

THE COURT: So you will be submitting --

MS. DUKE: We're submitting highlighted copies that also have it struck through.

THE COURT: Right. And also show the deposition designations --

MS. DUKE: Correct.

THE COURT: -- and cross designations. I think Mr. Metcalf was showing that to me, very nice, color coordinated.

As Mr. Sinclair recalls from the Adams trial, it was a little bit less -- much lower tech -- or less higher tech.

MS. DUKE: We have taken it to a newer high tech level.

THE COURT: Yes. They're not handwritten

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scribbled in the margins with me making my rulings in the margins as well.

MS. DUKE: Yes. As you indicated, Exhibits 1138 and 1139 were not objected to, so they're already into evidence.

THE COURT: All right.

MS. DUKE: Now we're moving to Dr. Jim Souza. And his is open with the exception of a very little bit of AEO that we can just mute the sound for.

THE COURT: All right.

******COURTROOM OPEN TO THE PUBLIC******

(Testimony of James Souza via video deposition.)

MS. DUKE: Your Honor, if we can blank the screen, and then I'll mute the sound.

THE COURT: Yes. Thank you.

(Video deposition resumed without audio.)

MS. DUKE: Now, we can go back onto the screen and sound.

(Video deposition resumed with audio.)

MS. DUKE: Your Honor, we would move for the admission of Exhibit 1357, which was the email that was just being discussed.

THE COURT: Counsel, was that the same as 1136 or was it additional?

MS. DUKE: The Dr. Bathina email is the same, but

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Dr. Souza's comments on top are obviously different. It's a different document. It just contains the same Dr. Bathina comments.

MR. SINCLAIR: No, I believe it's an identical document.

MS. DUKE: Is it?

THE COURT: I can't hear you, Mr. Sinclair. I'm sorry.

MR. SINCLAIR: I'm sorry. I think they're identical, Your Honor.

MS. DUKE: It looks like their Bates range may be. So we would still move for the admission just so the record is clear as to 1357.

THE COURT: Well, it would be potentially redundant, but I don't see how that can be of any harm.

Is there any objection?

MR. SINCLAIR: No, Your Honor.

THE COURT: All right. 1357 will be admitted. I've noted, though, that it appears to be the same as 1136.

(Plaintiffs' Exhibit No. 1357 admitted.)

THE COURT: Proceed.

(Video deposition resumed.)

(Video deposition of James Souza concluded.)

MS. DUKE: All right, Your Honor. Next we have Dr. Heggland, and his video is eight minutes and four

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seconds.

(Testimony of Erik Heggland via video deposition.)

MS. DUKE: All right, Your Honor. That's the conclusion of Dr. Heggland's.

We now have Jonathan Schott, and his is 14 minutes long. You all right with that?

THE COURT: Let's go ahead and play it.

(Testimony of Jonathan Schott via video deposition.)

MS. DUKE: Your Honor, that's the conclusion of that video testimony.

MR. SINCLAIR: We have another correction to the transcript. At page 110 at line 114, the transcript says, "We dropped our" -- O-U-R -- "utilization by 50 percent," and it was, "We dropped ER, emergency room, utilization by 50 percent."

THE COURT: All right. Appreciate your catching that. I assume that there is no disagreement. If there is, you can review the transcript, and we'll make that correction for the record.

Counsel, we'll reconvene at 8:30 tomorrow morning. We'll break at noon.

MR. GREENE: Is it 8:00, Your Honor, tomorrow?

THE COURT: Oh, better yet. I was hoping maybe we had suggested that. We will start at 8:00 tomorrow morning. We may break shortly before noon. I think my meeting is

actually scheduled to start at 11:30, but I think I have arranged for Judge Dale to cover the first part of the meeting. So we will start at 8:00 tomorrow morning. I'm glad I noted that, or I may have showed up here at 8:30 with everyone waiting. So we'll start at 8:00 tomorrow morning. We'll be in recess.

(Court recessed at 2:34 p.m.)

REPORTER'S CERTIFICATE

I, Tamara I. Hohenleitner, Official Court Reporter, County of Ada, State of Idaho, hereby certify:

That I am the reporter who transcribed the proceedings had in the above-entitled action in machine shorthand and thereafter the same was reduced into typewriting under my direct supervision; and

That the foregoing transcript contains a full, true, and accurate record of the proceedings had in the above and foregoing cause, which was heard at Boise, Idaho.

IN WITNESS WHEREOF, I have hereunto set my hand October 31, 2013.

-s-
Tamara I. Hohenleitner
Official Court Reporter
CSR No. 619